

## WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH	
County	Washington
Village or City	Hagerstown (No. 68)
2 FULL NAME Mary Adellie	
PERSONAL AND STATISTICAL PARTICULARS	
3 SEX Female	4 COLOR OR RACE W
5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word) Widow	
6 DATE OF BIRTH Don't Know, 1840	
(Month) (Day) (Year)	
7 AGE 75 yrs. mos. ds. If LESS than 1 day, hrs. OR min. ?	
8 OCCUPATION (a) Trade, profession, or particular kind of work. Housework	
(b) General nature of industry, business, or establishment in which employed (or employer)	
9 BIRTHPLACE (State or country) Ct	
10 NAME OF FATHER Potter	
11 BIRTHPLACE OF FATHER (State or country) Don't Know	
12 MAIDEN NAME OF MOTHER 11	
13 BIRTHPLACE OF MOTHER (State or country) 11	
14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE (Informant) Mrs. Chas. B. Elegal (Address) 329 S. Potowmack St	
15 Filed 1-22, 1915	

## 990 STATE OF MARYLAND CERTIFICATE OF DEATH

Registration Dist. No. 302

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

MEDICAL CERTIFICATE OF DEATH	
16 DATE OF DEATH Jan 20, 1915	
(Month) (Day) (Year)	
17 I HEREBY CERTIFY, That I attended deceased from Jan 1, 1914, to Jan 20, 1915, that I last saw her alive on Jan 18, 1915, and that death occurred on the date stated above, at 11 P. m. The CAUSE OF DEATH* was as follows:	
General exhaustion due to nervous condition	
(Duration) yrs. mos. 1 day	
Contributory (Secondary) Mental derangement	
(Duration) yrs. mos. 1 day	
(Signed) F. B. Hoffmeyer, M. D. Jan 21, 1915 (Address) Hagerstown, Md.	
*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.	
18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)	
At place of death yrs. mos. ds. In the State yrs. mos. ds.	
Where was disease contracted, If not at place of death?	
Former or usual residence	
19 PLACE OF BURIAL OR REMOVAL Rose Hill Cemetery	
DATE OF BURIAL Jan 22, 1915	
20 UNDERTAKER Krause Bros.	
ADDRESS 33 E. Wash. St.	

# REVISED UNITED STATES STANDARD

## CERTIFICATE OF DEATH

[Approved by U. S. Census and American Public Health Association.]

**Statement of occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*; *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary foreman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples:

(a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At Home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the disease causing death, state occupation at beginning or illness. If retired from business, that fact may be indicated thus: *Farmer* (*retired 6 yrs.*). For persons who have no occupation whatever, write *None*.

**Statement of cause of death**—Name, first, the disease causing death (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritonaeum, etc.*; *Carcinoma*, *Sarcoma*, etc., of ..... (name origin); "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Examples: *Measles* (disease causing death), *29 ds.*; *Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Malnutrition," "Old Age," "Shock," "Tetraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "Puerperal septicemia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent deaths state means of injury and quality as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train*—accident; *Revolver wound of head*—homicide; *Poisoned by carbolic acid*—probably suicide. The nature of the injury, as fracture or skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.

RECEIVED

FEB 6 1915

BUREAU, V. S.

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## 1 PLACE OF DEATH

County Washington

104

104

Village or City Hagerstown (No. Jail Alley)St. 5th Ward991 STATE OF MARYLAND  
CERTIFICATE OF DEATHRegistration Dist. No. 302

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME Anna Adams

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE Colored5 SINGLE,  
MARRIED,  
WIDOWED,  
OR DIVORCED

(Write the word)

Single6 DATE OF BIRTH Dec 2(Month) Dec (Day) 2 (Year) 19147 AGE 30If LESS than  
1 day, 0 hrs.  
yrs. 30 mos. 0 ds. OR min. 08 OCCUPATION Child(a) Trade, profession, or  
particular kind of work.(b) General nature of industry,  
business, or establishment in  
which employed (or employer)9 BIRTHPLACE Mayland

(State or country)

10 NAME OF FATHER William Adams11 BIRTHPLACE OF FATHER Jamaica West Indies

(State or country)

12 MAIDEN NAME OF MOTHER Lula Adams13 BIRTHPLACE OF MOTHER W Va

(State or country)

## 14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) William Adams(Address) Hagerstown, Md.15 Filed Aug 2, 1915 Henry Davis

REGISTRAR

If more blanks are needed, address State Registrar, 6 E. Franklin St., Balto., Requesting V. S. No. 1.

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH Jan 2, 1915(Month) Jan (Day) 2 (Year) 1915

17 I HEREBY CERTIFY, That I attended deceased from

Dec. 20, 1914, to Jan 2, 1915,that I last saw her alive on Dec. 31, 1914,and that death occurred on the date stated above, at 2 A.M.

The CAUSE OF DEATH\* was as follows:

Gastro-enteritis(Duration) 1 yrs. 1 mos. 0 ds.Contributory Gastro-enteritis

Secondary

(Duration) 1 yrs. 1 mos. 0 ds.(Signed) P. Laughlin, M. D.

(Jan 2, 1915) (Address)

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT

CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

## 18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place In the of death years months days State years months days

Where was disease contracted,

If not at place of death?

Former or

usual residence.

19 PLACE OF BURIAL OR REMOVAL HafewayDATE OF BURIAL Jan 2, 191520 UNDERTAKER AN CoffmanADDRESS Hagerstown

# REVISED UNITED STATES STANDARD

## CERTIFICATE OF DEATH

[Approved by U. S. Census and American Public Health Association.]

**Statement of occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples:

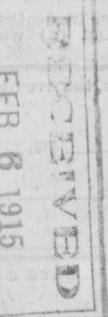
(a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer*, *Farm-laborer*, *Laborer*—*Cook*, *mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At Home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the disease causing death, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer* (*retired 6 yrs.*) For persons who have no occupation whatever, write *None*.

**Statement of cause of death**—Name, first, the disease

CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritonaeum*, etc., *Carcin-*

*oma*, *Sarcoma*, etc., or..... (name origin); "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Examples: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Anesthesia," "Anæmia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Mastitis," "Old Age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "Puerperal septicæmia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent deaths state MEANS OF INJURY and quality as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Recover wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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1 PLACE OF DEATH  
County Washington

Village or City Near Williamsport (No. 1)

992 STATE OF MARYLAND  
CERTIFICATE OF DEATH

Registration Dist. No. 301

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME Hermit Garfield Arndinger

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE White 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED Child  
(Write the word) single

6 DATE OF BIRTH

Dec 12, 1914  
(Month) (Day) (Year)

7 AGE

1 yrs. 24 mos. 24 ds. If LESS than 1 day, \_\_\_\_ hrs. OR \_\_\_\_ min. ?

8 OCCUPATION

(a) Trade, profession, or particular kind of work.  
(b) General nature of industry, business, or establishment in which employed (or employer)

Child

Child

9 BIRTHPLACE

(State or country)

Maryland

John W Arndinger

10 NAME OF FATHER

(State or country)

Maryland

11 BIRTHPLACE OF FATHER  
(State or country)

Sylvia Irene Bowers

12 MAIDEN NAME OF MOTHER

Ohio

13 BIRTHPLACE OF MOTHER  
(State or country)

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) John W Arndinger

(Address) Williamsport Md.

15

Filed Jan. 6th, 1915 by C. E. Richard  
Local REGISTRAR

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

Jan 5, 1915  
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from

Decem. 29, 1914 to Decem. 29, 1914

that I last saw him alive on December 29, 1914

and that death occurred on the date stated above, at 4:45 P.M.

The CAUSE OF DEATH\* was as follows:

Spasms due to  
Brain fever

(Duration) hrs. 14 ds.

Contributory  
Secondary

(Duration) hrs. 14 ds.

(Signed) Dr. D. T. Lesser, M. D.  
Jan 5, 1915 (Address) Williamsport Md.

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds. In the \_\_\_\_\_ State \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds

Where was disease contracted,  
If not at place of death?

Former or  
usual residence.

19 PLACE OF BURIAL OR REMOVAL

Williamsport Md DATE OF BURIAL Jan 7, 1915

20 UNDERTAKER

Lewis W Kieps ADDRESS Williamsport Md.

# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

[Approved by U. S. Census and American Public Health Association.]

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**Statement of cause of death**—Name, first, the disease causing death (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Group"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritonaeum*, etc.; *Carcinoma, Sarcoma*, etc., of..... (name origin); "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 d.; *Bronchopneumonia* (secondary), 10 d. Never report mere symptoms or terminal conditions, such as "Anæmia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Tetraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL septicæmia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. For violent deaths state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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1 PLACE OF DEATH	
County	Washington
Village or City	Near Antietam
2 FULL NAME	
Annie Victoria Baker	
PERSONAL AND STATISTICAL PARTICULARS	
3 SEX	4 COLOR OR RACE
Female	White
5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word)	widowed
6 DATE OF BIRTH	
April 12, 1855	
(Month)	(Day)
(Year)	
7 AGE	59 yrs. 8 mos. 27 ds.
If LESS than 1 day, hrs. OR min. ?	
8 OCCUPATION	
(a) Trade, profession, or particular kind of work.	
(b) General nature of industry, business, or establishment in which employed (or employer)	
Retired	
Housewife	
9 BIRTHPLACE (State or country)	
Maryland	
10 NAME OF FATHER	
Joseph Brampton	
11 BIRTHPLACE OF FATHER (State or country)	
Maryland	
12 MAIDEN NAME OF MOTHER	
Susan Pasnacht	
13 BIRTHPLACE OF MOTHER (State or country)	
Maryland	
14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE	
(Informant) William Baker	
(Address) Antietam Md	

15

Filed 1/9/1915 Chas. N. Hoffmaster

REGISTRAR

993 STATE OF MARYLAND  
CERTIFICATE OF DEATH

Registration Dist. No. 300

St. Ward

[If death occurred in  
a hospital or institution,  
give its NAME instead  
of street and number.]

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

Jan. 8, 1915

(Month)

(Day)

(Year)

17 I HEREBY CERTIFY, That I attended deceased from

June 1914, to Jan. 8, 1915,

that I last saw her alive on Jan. 5, 1915

and that death occurred on the date stated above, at 530 p.m.

The CAUSE OF DEATH\* was as follows:

Consumptive Tuberculosis

Several years

(Duration) yrs. mos. ds.

Contributory  
Secondary

(Duration) yrs. mos. ds.

(Signed)

E. G. Garrett, M. D.

1/9/1915 (Address) Sharpsburg Md.

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT  
CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCI-  
DENTAL, SUICIDAL, or HOMICIDAL.18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS,  
OR RECENT RESIDENTS)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted,  
If not at place of death?Former or  
usual residence

19 PLACE OF BURIAL OR REMOVAL

Sharpsburg Md Jan 16, 1915

20 UNDERTAKER

ADDRESS

Albert Lea or Williamsport Md

# REVISED UNITED STATES STANDARD

## CERTIFICATE OF DEATH

[Approved by U. S. Census and American Public Health Association.]

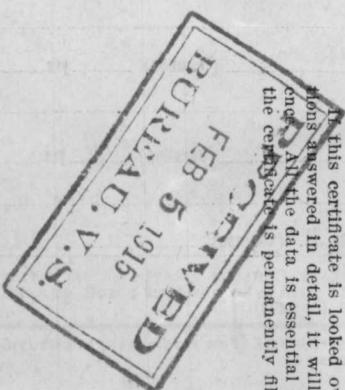
Association.]

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*oma, Sarcoma, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: Measles (disease causing death), 29 ds.; Bronchopneumonia (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Anæmia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. For violent deaths state means of INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide. The nature of the injury, as fracture of skull, and consequences (e. g., sepsis, tetanus) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)*

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1 PLACE OF DEATH		189
County	Washington	
Village or City	Hagerstown (No. 120, Fairground Ave. <sup>14th</sup> St., Ward)	
2 FULL NAME Charles P. Baker		
PERSONAL AND STATISTICAL PARTICULARS		
3 SEX	4 COLOR OR RACE	5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word)
Male	White	single
6 DATE OF BIRTH		
Jan. 20, 1912 (Month) (Day) (Year)		
7 AGE	2 yrs. 11 mos. 16 ds.	If LESS than 1 day, hrs. OR min. ?
8 OCCUPATION (a) Trade, profession, or particular kind of work (b) General nature of industry, business, or establishment in which employed (or employer)		
Tavern		
9 BIRTHPLACE (State or country)		
Hagerstown		
10 NAME OF FATHER		
Charles Baker		
11 BIRTHPLACE OF FATHER (State or country)		
Hagerstown Md		
12 MAIDEN NAME OF MOTHER		
Anna Morgan		
13 BIRTHPLACE OF MOTHER (State or country)		
Tilmington Md		
14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE (Informant)		
Charles Baker		
120 Fairground Ave Hagerstown (Address)		
15	Filed 1/19, 1915 - Henry Davis	

## 994 STATE OF MARYLAND CERTIFICATE OF DEATH

Registration Dist. No. 302

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

MEDICAL CERTIFICATE OF DEATH		
16 DATE OF DEATH		
Jan. 16, 1915 (Month) (Day) (Year)		
17 I HEREBY CERTIFY, That I attended deceased from July 5, 1914, to Jan. 16, 1915, that I last saw him alive on Jan. 16, 1915, and that death occurred on the date stated above, at 7 P. m.		
The CAUSE OF DEATH* was as follows:		
Malaria		
(Duration) yrs. 6 mos. 0 ds.		
Contributory Secondary		
(Duration) yrs. 0 mos. 0 ds.		
(Signed) H. P. Beucler, M.D., M. D. Jan. 18 <sup>th</sup> , 1915 (Address) Hagerstown		
*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.		
18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)		
At place of death yrs. 0 mos. 0 ds. In the State yrs. 0 mos. 0 ds.		
Where was disease contracted, if not at place of death?		
Former or usual residence		
19 PLACE OF BURIAL OR REMOVAL		
Ros Hill Hagerstown Jan 19, 1915		
DATE OF BURIAL		
20 UNDERTAKER		
S. Kella Loman Hagerstown Md		
ADDRESS		

If more blanks are needed, address State Registrar, 6 E. Franklin St., Balto., Requesting V. S. No. 1.

# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

[Approved by U. S. Census and American Public Health Association.]

**Statement of occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter*, *Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary, to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At Home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the disease causing death, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.)*. For persons who have no occupation whatever, write *None*.

**Statement of cause of death**—Name, first, the disease causing death (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritonaeum*, etc., *Carcinoma*, *Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "Puerperal septicæmia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent deaths state means of INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.

**RECEIVED**  
FEB 6 1915  
BUREAU, V.S.

## WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See Instructions on back of certificate.

1 PLACE OF DEATH

County Washington ✓ 995 STATE OF MARYLAND  
Village or City Hagerstown (No. 112 West Bethel CERTIFICATE OF DEATH  
Registration Dist. No. 302  
St. 5<sup>th</sup> Ward)

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME Unnamed child of Frank and Lillie Balis

PERSONAL AND STATISTICAL PARTICULARS

3 SEX <u>male</u>	4 COLOR OR RACE <u>colored</u>	5 SINGLE, <u>married</u> MARRIED, <u>single</u> WIDOWED, OR DIVORCED (Write the word)
6 DATE OF BIRTH		January 22, 1915 (Month) (Day) (Year)
7 AGE		If LESS than 1 day, <u>4</u> hrs. OR <u>45</u> min. ? yrs. mos. ds.
8 OCCUPATION (a) Trade, profession, or particular kind of work... <u>infant</u>		
8 OCCUPATION (b) General nature of industry, business, or establishment in which employed (or employer) <u>✓</u>		
9 BIRTHPLACE (State or country) <u>Maryland</u>		
10 NAME OF FATHER <u>Wm. Frank Balis</u>		
11 BIRTHPLACE OF FATHER (State or country) <u>Virginia</u>		
12 MAIDEN NAME OF MOTHER <u>Lillie Brown</u>		
13 BIRTHPLACE OF MOTHER (State or country) <u>Virginia</u>		
14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE (Informant) <u>Wm. F. Balis</u>		
15 (Address) <u>112 West Bethel Hagerstown, Md.</u>		
16 DATE OF DEATH Jan. 22, 1915 (Month) (Day) (Year)		
17 I HEREBY CERTIFY, That I attended deceased from Jan. 22, 1915, to Jan. 22, 1915, that I last saw him alive on Jan. 22, 10 a.m., 1915, and that death occurred on the date stated above, at 2 p.m. The CAUSE OF DEATH* was as follows: <u>Premature Birth</u>		
18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS) At place of death yrs. mos. ds. In the State yrs. mos. ds. Where was disease contracted, If not at place of death? Former or usual residence.		
19 PLACE OF BURIAL OR REMOVAL <u>Halfway, Md.</u> DATE OF BURIAL <u>1-23-1915</u>		
20 UNDERTAKER <u>A. R. Coffman Hagerstown, Md.</u> ADDRESS		

# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

[Approved by U. S. Census and American Public Health Association.]

**Statement of occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples:

(a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second

statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer-Coat mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework, or At Home*, and children, not gainfully employed, as *At school or At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid, etc.* If the occupation has been changed or given up on account of the disease causing death, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.)* For persons who have no occupation whatever, write *None*.

**Statement of cause of death**—Name, first, the disease causing death (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritonaeum, etc., Cancer*.

*oma, Sarcoma, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent) affection need not be stated unless important. Examples: *Measles* (disease causing death), 29 d.; *Bronchopneumonia* (secondary), 10 d. Never report were symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Mastitis," "Old Age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. For violent deaths state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *scpsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.

RECEIVED

FEB 6 1915

BUREAU, U. S.

## WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See Instructions on back of certificate.

1 PLACE OF DEATH County <u>Washington</u>		996 STATE OF MARYLAND CERTIFICATE OF DEATH Registration Dist. No. <u>302</u>		
Village or City <u>Hagerstown</u> (No. <u>Valley Hotel</u> )		St. <u>5th</u> Ward		
2 FULL NAME <u>Unnamed Child</u>		[If death occurred in a hospital or institution, give its NAME instead of street and number.] <u>Barth</u>		
PERSONAL AND STATISTICAL PARTICULARS				
3 SEX <u>Male</u>	4 COLOR OR RACE <u>white</u>	5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word) <u>Single</u>	16 DATE OF DEATH <u>Jan 16</u> , 1915 (Month) (Day) (Year)	
6 DATE OF BIRTH <u>Jan</u> , 1915 (Month) (Day) (Year)		MEDICAL CERTIFICATE OF DEATH		
7 AGE <u>— yrs. — mos. — ds.</u>		If LESS than 1 day, hrs. OR min. ?		
8 OCCUPATION (a) Trade, profession, or particular kind of work. (b) General nature of industry, business, or establishment in which employed (or employer) <u>—</u>		17 I HEREBY CERTIFY, That I attended deceased from <u>—</u> , 1915, to <u>—</u> , 1915, that I last saw h. <u>alive</u> on <u>—</u> , 1915, and that death occurred on the date stated above, at <u>—</u> m. The CAUSE OF DEATH* was as follows:		
9 BIRTHPLACE (State or country) <u>Maryland</u>		<u>formatus first, being necessitated by placenta praevia.</u>		
10 NAME OF FATHER <u>Lud. Barth</u>		18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS) At place of death <u>— yrs. — mos. — ds.</u> In the State <u>— yrs. — mos. — ds.</u>		
11 BIRTHPLACE OF FATHER (State or country) <u>Indiana</u>		Where was disease contracted, if not at place of death?		
12 MAIDEN NAME OF MOTHER <u>Annie Miller</u>		Former or usual residence.		
13 BIRTHPLACE OF MOTHER (State or country) <u>Pa</u>		19 PLACE OF BURIAL OR REMOVAL <u>Hagerstown, Md</u> DATE OF BURIAL <u>Jan 17</u> , 1915		
14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE (Informant) <u>Annie Miller</u>		20 UNDERAKER <u>A. K. Cogman</u> ADDRESS <u>Hagerstown, Md</u>		
(Address) <u>Hagerstown, Md</u>				
15 Filed <u>1/16</u> , 1915	Henry Davis	REGISTRAR		

# REVISED UNITED STATES STANDARD

## CERTIFICATE OF DEATH

[Approved by U. S. Census and American Public Health Association.]

**Statement of occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples:

(a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return “*Laborer*,” “*Foreman*,” “*Manager*,” “*Dealer*,” etc., without more precise specification as *Day laborer*, *Farm laborer*, *Laborer*—*Coult mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At Home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the disease causing death, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer* (*retired 6 yrs.*) For persons who have no occupation whatever, write *None*.

**Statement of cause of death**—Name, first, the disease causing death (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is “*Epidemic cerebrospinal meningitis*”); *Diphtheria* (avoid use of “*Croup*”); *Typhoid fever* (never report “*Typhoid pneumonia*”); *Lobar pneumonia*; *Bronchopneumonia* (“*Pneumonia*,” unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritonaeum*, etc., *Carcin*.

oma

*Sarcoma*, etc., of..... (name origin); “*Cancer*” is less definite; avoid use of “*Tumor*” for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic vulvar heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as “*Anæmia*,” “*Anæmia*” (merely symptomatic), “*Atrophy*,” “*Collapse*,” “*Coma*,” “*Convulsions*,” “*Debility*” (“*Con genital*,” “*Senile*,” etc.), “*Dropsey*,” “*Exhaustion*,” “*Heart failure*,” “*Haemorrhage*,” “*Inanition*,” “*Mars mus*,” “*Old Age*,” “*Shock*,” “*Uraemia*,” “*Weakness*,” etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as “*Puerperal septicæ mia*,” “*Puerperal peritonitis*,” etc. State cause for which surgical operation was undertaken. For violent deaths state means of injury and quality as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Recover wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of “*Contributory*.” (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.

RECEIVED

FEB 6 1915

BUREAU, V. S.

## WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

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## 1 PLACE OF DEATH

County Washington

Village or City Clear Spring (No.)

997

STATE OF MARYLAND  
CERTIFICATE OF DEATHRegistration Dist. No. 303St. Ward)

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

## 2 FULL NAME

Mary E. Beyard

## PERSONAL AND STATISTICAL PARTICULARS

## 3 SEX

Female white

5 SINGLE,  
MARRIED,  
WIDOWED,  
OR DIVORCED  
(Write the word)

widowed

## 6 DATE OF BIRTH

Oct 14, 1848  
(Month) (Day) (Year)

## 7 AGE

66 yrs. 2 mos. 19 ds.

If LESS than  
1 day, ... hrs.  
OR min. ?

## 8 OCCUPATION

(a) Trade, profession, or  
particular kind of work.

Housewife

(b) General nature of industry,  
business, or establishment in  
which employed (or employer)

## 9 BIRTHPLACE

(State or country)

Maryland

## 10 NAME OF FATHER

Henry Rowland

## 11 BIRTHPLACE OF FATHER

(State or country)

Pa

## 12 MAIDEN NAME OF MOTHER

Elizabeth Myley

## 13 BIRTHPLACE OF MOTHER

(State or country)

Pa

## 14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Albert Beyard

(Address)

Clear Spring

## 15

Filed

July 4, 1915David S. Miller

REGISTRAR

## MEDICAL CERTIFICATE OF DEATH

## 16 DATE OF DEATH

Jan 3, 1915  
(Month) (Day) (Year)

17 I HEREBY CERTIFY That I attended deceased from  
April 3, 1914 to January 3, 1915,  
that I last saw her alive on Jan. 2, 1915,

and that death occurred on the date stated above, at 2-15 A.m.

The CAUSE OF DEATH\* was as follows:

Chronic Valvular Heart  
Disease

(Duration) yrs. mos. ds.

Contributory  
Secondary

(Duration) yrs. mos. ds.

(Signed) Jonathan P. Perry M. D.  
Jan 3, 1915 (Address) Clear Spring, Md.

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

## 18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death yrs. mos. ds. In the State yrs. mos. ds

Where was disease contracted, If not at place of death?

Former or usual residence

## 19 PLACE OF BURIAL OR REMOVAL

Lutheran Cemetery, Clear Spring Jan. 5, 1915

## 20 UNDERTAKER

L. P. Snyder ADDRESS  
Clear Spring

# REVISED UNITED STATES STANDARD

## CERTIFICATE OF DEATH

[Approved by U. S. Census and American Public Health Association.]

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(a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At Home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the disease causing death, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.)*. For persons who have no occupation whatever, write *None*.

**Statement of cause of death**—Name, first, the disease causing death (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritonaeum*, etc., *Carcin-*

*oma*, *Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Examples: *Measles* (disease causing death), 29 d.s.; *Bronchopneumonia* (secondary), 10 d.s. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Con genital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Migraines," "Old Age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "Puerperal septicemia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent deaths state means of INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.

RECEIVED

FEB 5 1915

BUREAU, V.S.

## WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

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1 PLACE OF DEATH  
County Washington

V  
64  
Village or City Hagerstown (No. 541, Spruce St.) St. 2<sup>nd</sup> Ward)

## 2 FULL NAME

Frederick A. Bierly.

STATE OF MARYLAND  
CERTIFICATE OF DEATHRegistration Dist. No. 302

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX male 4 COLOR OR RACE white 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED married  
(Write the word)

## 6 DATE OF BIRTH

Jan. 26, 1845.  
(Month) (Day) (Year)

## 7 AGE

70 yrs. — mos. 3 ds. If LESS than  
1 day, \_\_\_\_ hrs.  
OR \_\_\_\_ min. ?

## 8 OCCUPATION

(a) Trade, profession, or particular kind of work. Retired Harness Worker.  
(b) General nature of industry, business, or establishment in which employed (or employer) " " "

9 BIRTHPLACE  
(State or country)

Maryland.  
Unknown

PARENTS  
10 NAME OF FATHER

Unknown

11 BIRTHPLACE OF FATHER  
(State or country) " "

## 12 MAIDEN NAME OF MOTHER

" "

13 BIRTHPLACE OF MOTHER  
(State or country)

" "

## 14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Mrs. F. A. Bierly

(Address) 541 Spruce St.

## 15

Filed 1/30, 1915

5 Harry Davis  
REGISTRAR

If more blanks are needed, address State Registrar, 6 E. Franklin St., Balto., Requesting V. S. No. 1.

## MEDICAL CERTIFICATE OF DEATH

## 16 DATE OF DEATH

Jan. 29, 1915  
(Month) (Day) (Year)

## 17 I HEREBY CERTIFY, That I attended deceased from

Jan. 29, 1915, to Jan. 29, 1915,  
that I last saw him alive on Jan. 29, 1915,  
and that death occurred on the date stated above, at 12 m.

The CAUSE OF DEATH\* was as follows:

Gastroenteritis  
Abscess  
(Duration) yrs. mos. ds.

Contributory  
Secondary

Heart disease  
(Duration) yrs. mos. ds.  
(Signed) Henry Davis, M. D.  
Jan. 30, 1915 (Address) Hagerstown, Md.

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

## 18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence.

## 19 PLACE OF BURIAL OR REMOVAL

Rose Hill Cemetery DATE OF BURIAL  
4/1, 1915

20 UNDERTAKER

Constable Dow ADDRESS  
Hagerstown Md.

# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

[Approved by U. S. Census and American Public Health Association.]

**Statement of occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples:

(a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At Home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the disease causing death, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.)* For persons who have no occupation whatever, write *None*.

**Statement of cause of death**—Name, first, the disease causing death (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Group"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcin-*

*oma*, *Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.*; *Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Anæmia," "Anæmia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uratremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "Puerperal septicemia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent deaths state means of injury and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.

RECEIVED

FEB 6 1915

BUREAU, V.S.

## WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH

County *Washington* (40) 999 STATE OF MARYLAND  
Village or City *Mt. Brier* (No. ....) CERTIFICATE OF DEATH  
Registered No. *316*

St. .... Ward) [If death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME *John Robert Brown*

PERSONAL AND STATISTICAL PARTICULARS

3 SEX *Male* 4 COLOR OR RACE *Colored* 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED *Married*  
(Write the word)

6 DATE OF BIRTH *Second* (Month) *8* (Day) *1841* (Year)

7 AGE *73* yrs. *11* mos. *7* ds. If LESS than 1 day, ... hrs. OR ... min. ?

8 OCCUPATION  
(a) Trade, profession, or particular kind of work *Labour*  
(b) General nature of industry, business, or establishment in which employed (or employer) *020*

9 BIRTHPLACE  
(State or country) *Washington, D. C.*

PARENTS

10 NAME OF FATHER *John Brown*  
11 BIRTHPLACE OF FATHER  
(State or country) *Don't know*  
12 MAIDEN NAME OF MOTHER *Miranda Patterson*  
13 BIRTHPLACE OF MOTHER  
(State or country) *Don't know*

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE  
(Informant) *Daniel Calaman*  
(Address) *Reddsville, Md.*

15 Filed *Jan. 15, 1916* At *4 N. Sumner*

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH *Jan 14* (Month) *1916* (Year)

17 I HEREBY CERTIFY, That I attended deceased from *May*, 1915, to *Jan 6*, 1916, that I last saw him alive on *Jan 6*, 1916, and that death occurred on the date stated above, at *4 A. M.*, The CAUSE OF DEATH\* was as follows: *Cancer of Liver and Gall Bladder*

(Duration) .... yrs. .... mos. .... ds.

Contributory  
(Secondary)

(Duration) .... yrs. .... mos. .... ds.

(Signed) *John D. Dunn*, M. D.  
*Jan 16, 1916* (Address) *Reddsville*

\*State the DISEASE CAUSING DEATH, or, In deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)  
At place of death .... yrs. .... mos. .... ds. In the State .... yrs. .... mos. .... ds  
Where was disease contracted, if not at place of death?  
Former or usual residence

19 PLACE OF BURIAL OR REMOVAL *Red Hill* DATE OF BURIAL *Jan. 16, 1916*

20 UNDERTAKER *M. & E. D. Dunn* ADDRESS *Reddsville*

# REvised UNITED STATES STANDARD

## CERTIFICATE OF DEATH

[Approved by U. S. Census and American Public Health

Association.]

**Statement of occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Composer*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary foreman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At Home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the disease causing death, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.)*. For persons who have no occupation whatever, write *None*.

**Statement of cause of death**—Name, first, the disease causing death (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritonaeum*, etc. *Carcin-*

*oma*, *Sarcoma*, etc., of ..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 *ds.*; *Bronchopneumonia* (secondary), 10 *ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Con genital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "Puerperal septicæmia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent deaths state means of injury and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *spasis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.

RECEIVED

FEB 8 1915

BUREAU, V.S.

## WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

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1 PLACE OF DEATH County <u>Washington</u>		1000 81	STATE OF MARYLAND CERTIFICATE OF DEATH	
Village or City <u>Hancock</u> (No.)		Registration Dist. No. <u>304</u>		St.; Ward)
<b>2 FULL NAME</b> <u>Gertrude Butler</u>				
PERSONAL AND STATISTICAL PARTICULARS				
3 SEX <u>Female</u>	4 COLOR OF HAIR <u>White</u>	5 SINGLE, MARRIED, WIDOWED, OR DIVORCED <u>Married.</u> (Write the word)	16 DATE OF DEATH <u>Jan 5</u> (Month) (Day) (Year)	
6 DATE OF BIRTH <u>April 5</u> (Month) (Day) (Year)	7 AGE <u>79 yrs. 9 mos. 0 ds.</u> If LESS than 1 day, hrs. OR min. ?		17 I HEREBY CERTIFY, That I attended deceased from <u>1/1</u> , 1915 to <u>1/5</u> , 1915, that I last saw her alive on <u>1/4</u> , 1915, and that death occurred on the date stated above, at <u>50</u> m.	
8 OCCUPATION (a) Trade, profession, or particular kind of work. <u>Housewife.</u> (b) General nature of industry, business, or establishment in which employed (or employer)		The CAUSE OF DEATH* was as follows: <u>Arterio-Sclerosis</u>		
9 BIRTHPLACE (State or country) <u>Germany</u>		8 (Duration) yrs. mos. ds. Contributory Secondary		
10 NAME OF FATHER <u>Conrad Anthony</u>		7 (Duration) yrs. mos. ds. <u>J. H. Dray</u> M.D.		
11 BIRTHPLACE OF FATHER (State or country) <u>Germany</u>		(Signed) <u>1/6, 1915</u> (Address) <u>Hancock, Md.</u>		
12 MAIDEN NAME OF MOTHER <u>Not Known</u>		* State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.		
13 BIRTHPLACE OF MOTHER (State or country) <u>Germany</u>		18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS) At place of death yrs. mos. ds. In the State yrs. mos. ds Where was disease contracted, If not at place of death? Former or usual residence		
14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE (Informant) <u>L. A. Butler</u> (Address) <u>Bucksdale Pa.</u>		19 PLACE OF BURIAL OR REMOVAL <u>Hancock Md.</u> Jan 7, 1915 20 UNDERTAKER <u>McGrath &amp; Son Hancock Md.</u>		
15 Filed <u>Jan 6, 1915</u> <u>J. P. Furtach</u>		DATE OF BURIAL ADDRESS		

If more blanks are needed, address State Registrar, 6 E. Franklin St., Balto., Requesting V. S. No. 1.

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

[Approved by U. S. Census and American Public Health Association.]

**Statement of occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter*, *Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the disease causing death, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.)* For persons who have no occupation whatever, write *None*.

**Statement of cause of death**—Name, first, the disease causing death (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Group"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritonaeum, etc., Carcin-*

*oma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Examples: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Anæmia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Con genital," "Senile," etc.), "Dropsey," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL septicaemia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. For violent deaths state means of INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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RECEIVED	FEB 5 1915
BUREAU, V.S.	

## WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

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1 PLACE OF DEATH		31	1001	STATE OF MARYLAND CERTIFICATE OF DEATH	
County. <u>Washington</u>		31		Registration Dist. No. <u>304</u>	
Village or City <u>Hancock</u> (No. <u>111</u> )				St. <u>Ward</u> )	
2 FULL NAME <u>Catherine Marie Byroads.</u>				[If death occurred in a hospital or institution, give its NAME instead of street and number.]	
PERSONAL AND STATISTICAL PARTICULARS					
3 SEX <u>Female.</u>	4 COLOR OR RACE <u>White.</u>	5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word)	Married.		
6 DATE OF BIRTH <u>Oct 30</u>		(Month) <u>Oct</u>	(Day) <u>30</u>	(Year) <u>1894</u>	
7 AGE <u>20 yrs. 2 mos. 13 ds.</u>	If LESS than 1 day, <u>hrs.</u> OR <u>min. ?</u>				
8 OCCUPATION <u>Housewife</u>					
(a) Trade, profession, or particular kind of work <u>Housewife</u>					
(b) General nature of industry, business, or establishment in which employed (or employer)					
9 BIRTHPLACE (State or country) <u>Hancock Md.</u>					
10 NAME OF FATHER <u>Samuel Walters</u>					
11 BIRTHPLACE OF FATHER (State or country) <u>Hancock Md.</u>					
12 MAIDEN NAME OF MOTHER <u>Mary E. Dunnigan</u>					
13 BIRTHPLACE OF MOTHER (State or country) <u>Morrisville Md.</u>					
14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE (Informant) <u>John M. Byroads.</u> (Address) <u>Hancock Md.</u>					
15 Filed <u>Jan 3, 1915</u> J. P. Jenkins					
REGISTRAR					
16 DATE OF DEATH <u>Jan 13<sup>th</sup></u> , 1915 (Month) <u>Jan</u> (Day) <u>13</u> (Year) <u>1915</u>					
17 I HEREBY CERTIFY, That I attended deceased from <u>Jan 8<sup>th</sup></u> , 1915, to <u>Jan 13<sup>th</sup></u> , 1915, that I last saw <u>her</u> alive on <u>Jan 13<sup>th</sup></u> , 1915, and that death occurred on the date stated above, at <u>3:30 p.m.</u> The CAUSE OF DEATH* was as follows:					
<u>Tuberculosis of the intestines</u>					
(Duration) <u>6 mos.</u>					
Contributory (Secondary)					
(Signed) <u>J. P. Jenkins</u> M. D. (Address) <u>Hancock Md.</u>					
(Duration) <u>6 mos.</u>					
*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.					
18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)					
At place of death <u>years</u> <u>months</u> <u>days</u> In the State <u>years</u> <u>months</u> <u>days</u>					
Where was disease contracted, if not at place of death?					
Former or usual residence					
19 PLACE OF BURIAL OR REMOVAL St. Peter's Catholic Cem. Hancock Md.					
DATE OF BURIAL <u>Jan 15, 1915</u>					
20 UNDERTAKER <u>J. P. Jenkins</u> ADDRESS <u>Hancock Md.</u>					

# REVISED UNITED STATES STANDARD

## CERTIFICATE OF DEATH

[Approved by U. S. Census and American Public Health

Association.]

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**Statement of cause of death**—Name, first, the disease causing death (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum, etc.*; *Carcin-*

*oma*, *Sarcoma*, etc., of ..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 d.; *Bronchopneumonia* (secondary), 10 d. Never report mere symptoms or terminal conditions, such as "Asthma," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Tetraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "Puerperal septicemia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent deaths state means of injury and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probable* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.



## WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

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1 PLACE OF DEATH  
County Washington 1002  
Village or City near Gilhamton (No.) (S)

2 FULL NAME (still born) about 3d month Bynwaters

3 SEX M 4 COLOR OR RACE white 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED Single  
(Write the word)

6 DATE OF BIRTH Jan 4, 1915  
(Month) (Day) (Year)

7 AGE — If LESS than 1 day, \_\_\_\_ hrs.  
\_\_\_\_ yrs. \_\_\_\_ mos. \_\_\_\_ ds. OR min. ?

8 OCCUPATION  
(a) Trade, profession, or particular kind of work. 000  
(b) General nature of industry, business, or establishment in which employed (or employer) —

9 BIRTHPLACE  
(State or country) MD

10 NAME OF FATHER John E. Bynwaters  
11 BIRTHPLACE OF FATHER  
(State or country) VA

12 MAIDEN NAME OF MOTHER Viola K. Perdahl  
13 BIRTHPLACE OF MOTHER  
(State or country) VA

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE  
(Informant) John E. Bynwaters  
(Address) Fair Play MD

15 Filed Jan 5, 1915 V. M. Reichard  
REGISTRAR

St.; Ward) — [If death occurred in a hospital or institution, give its NAME instead of street and number.]

16 DATE OF DEATH Jan 4, 1915  
(Month) (Day) (Year)

17 I HEREBY CERTIFY, that I attended deceased from Jan 4, 1915, to Jan 4, 1915, that I last saw him alive on —, 19— and that death occurred on the date stated above, at — m. The CAUSE OF DEATH\* was as follows:

Possibly 3d stage of foetus which was not formed  
Contributory Secondary  
(Duration) yrs. mos. ds.  
(Signed) V. M. Reichard, M. D.  
Jan 5, 1915 (Address) Fair Play

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)  
At place of death \_\_\_\_ yrs. \_\_\_\_ mos. \_\_\_\_ ds. In the State \_\_\_\_ yrs. \_\_\_\_ mos. \_\_\_\_ ds  
Where was disease contracted, If not at place of death?  
Former or usual residence.

19 PLACE OF BURIAL OR REMOVAL Anywhere DATE OF BURIAL Jan 5, 1915  
20 UNDERTAKER John E. Bynwaters ADDRESS Fair Play

If more blanks are needed, address State Registrar, 6 E. Franklin St., Balt., Requesting V. S. No. 1.

# REVISED UNITED STATES STANDARD

## CERTIFICATE OF DEATH

[Approved by U. S. Census and American Public Health Association.]

**Statement of occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Composer*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer*, *Farm laborer*, *Laborer—Coat niner*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At Home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the disease causing death, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer* (*retired 6 yrs.*) For persons who have no occupation whatever, write *None*.

**Statement of cause of death**—Name, first, the disease causing death (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); <sup>3</sup>*Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia", unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritonaeum, etc.*, *Carcin-*

*oma, Sarcoma*, etc., of..... (name origin); "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.*; *Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Con genital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marsasmus," "Old Age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. For violent deaths state means of INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *spasis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.



## WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH		1003	STATE OF MARYLAND		
County, <i>Washington</i>		CERTIFICATE OF DEATH			
Village or City <i>Dry Run</i> (No.)		Registration Dist. No. <i>303</i>			
2 FULL NAME <i>Paul Forsyth Carbaugh</i>		St. <i>Ward</i> )			
[If death occurred in a hospital or institution, give its NAME instead of street and number.]					
PERSONAL AND STATISTICAL PARTICULARS					
3 SEX <i>Male</i>	4 COLOR OR RACE <i>White</i>	5 SINGLE, MARRIED, WIDOWED, OR DIVORCED <i>Single</i> (Write the word)			
6 DATE OF BIRTH <i>December 15<sup>th</sup>, 1914</i>		(Month) <i>Dec.</i>	(Day) <i>15</i>	(Year) <i>1914</i>	
7 AGE <i>23</i>	yrs. <i>23</i>	mos. <i>0</i>	ds. <i>0</i>	If LESS than 1 day, _____ hrs. <i>0</i>	OR min. <i>0</i>
8 OCCUPATION (a) Trade, profession, or particular kind of work <i>Gas boy</i> (b) General nature of industry, business, or establishment in which employed (or employer) <i>Gas boy</i>					
9 BIRTHPLACE (State or country) <i>Maryland</i>					
10 NAME OF FATHER <i>Jacob J. Carbaugh</i>					
11 BIRTHPLACE OF FATHER (State or country) <i>Maryland</i>					
12 MAIDEN NAME OF MOTHER <i>Lottie V. Forsyth</i>					
13 BIRTHPLACE OF MOTHER (State or country) <i>Maryland</i>					
14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE (Informant) <i>Isaac Forsyth</i> (Address) <i>Clearspring Rd.</i>					
15 Filed <i>Jan. 7<sup>th</sup>, 1915</i>		Signature <i>David S. Miller</i>		REGISTRAR	

MEDICAL CERTIFICATE OF DEATH					
16 DATE OF DEATH <i>Jan. 7<sup>th</sup>, 1915</i>					
(Month) <i>Jan.</i> (Day) <i>7<sup>th</sup></i> (Year) <i>1915</i>					
17 I HEREBY CERTIFY, That I attended deceased from <i>Dec. 15<sup>th</sup>, 1914</i> , to <i>Jan. 7<sup>th</sup>, 1915</i> , that I last saw him alive on <i>Dec. 15<sup>th</sup>, 1914</i> , and that death occurred on the date stated above, at <i>12:30 P.M.</i>					
The CAUSE OF DEATH was as follows: <i>Gas boy</i>					
(Duration) yrs. mos. ds.					
Contributory Secondary					
(Duration) yrs. mos. ds.					
(Signed) <i>Matthew P. Perry, M.D.</i> (Address) <i>Clearspring Rd.</i>					
*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.					
18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)					
At place _____ In the _____ of death yrs. mos. ds. State yrs. mos. ds.					
Where was disease contracted, if not at place of death?					
Former or usual residence					
19 PLACE OF BURIAL OR REMOVAL <i>St. Paul's Cemetery</i> DATE OF BURIAL <i>Jan. 8, 1915</i>					
20 UNDERTAKER <i>Frank's Body Co.</i> ADDRESS <i>Clearspring Rd.</i>					

# REVISED UNITED STATES STANDARD

## CERTIFICATE OF DEATH

[Approved by U. S. Census and American Public Health Association.]

**Statement of occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner, (b) Cotton mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework, or At Home*, and children, not gainfully employed, as *At school or At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid, etc.* If the occupation has been changed or given up on account of the disease causing death, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.)* For persons who have no occupation whatever, write *None*.

**Statement of cause of death**—Name, first, the disease causing death (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritonaeum, etc., Cancer*,

*oma, Sarcoma, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Examples: Measles (disease causing death), 29 ds.; Bronchopneumonia (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Contingent," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Mastitis," "Old Age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. For violent deaths state means of INJURY and quality as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide. The nature of the injury, as fracture of skull, and consequences (e. g., sepsis, tetanus) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)*

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.

RECEIVED

FEB 5 1915

BUREAU, V. S.

## WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

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1 PLACE OF DEATH  
County *Baltimore*

Village or City *Freaysville* No. *5*

## 2 FULL NAME

1004 STATE OF MARYLAND  
CERTIFICATE OF DEATH

Registration Dist. No. *316*

St. *Ward*)

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

3 SEX *Male* 4 COLOR OR RACE *White* 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED *Married* *Infant* [Write the word]

## 6 DATE OF BIRTH

*Jan 2*, 1915  
(Month) (Day) (Year)

## 7 AGE

— yrs. — mos. — ds. If LESS than 1 day, — hrs. OR — min. ?

## 8 OCCUPATION

(a) Trade, profession, or particular kind of work *None*

(b) General nature of industry, business, or establishment in which employed (or employer) *None*

## 9 BIRTHPLACE

(State or country) *Freaysville Md*

## 10 NAME OF FATHER

11 BIRTHPLACE OF FATHER  
(State or country) *Freaysville Md*

## 12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER  
(State or country) *Freaysville Md*

## 14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) *C. M. Clappett*

(Address) *Freaysville Md*

15

Filed *2-8-*

191

5 Hh Dm

REGISTRAR

## MEDICAL CERTIFICATE OF DEATH

## 16 DATE OF DEATH

*Jan 2*, 1915  
(Month) (Day) (Year)

## 17 I HEREBY CERTIFY, That I attended deceased from

*Jan 2*, 1915 to *Jan 2*, 1915, and that I last saw him alive on *Jan 2*, 1915

and that death occurred on the date stated above, at *8:30 a.m.*

The CAUSE OF DEATH\* was as follows:

*5 months Febrile  
Inflammation*

Contributory *Still-Born*  
Secondary *None*

(Duration) yrs. mos. ds.

(Signed) *W. H. Dunning* M. D.  
*Jan 3, 1915* (Address) *Freaysville Md*

\* State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

## 18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, If not at place of death?

Former or usual residence.

## 19 PLACE OF BURIAL OR REMOVAL

*On Prism*

## DATE OF BURIAL

*Jan 2*, 1915

## 20 UNDERTAKER

ADDRESS

# REVISED UNITED STATES STANDARD

## CERTIFICATE OF DEATH

[Approved by U. S. Census and American Public Health Association.]

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**Statement of cause of death**—Name, first, the disease causing death (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Group"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite): *Tuberculosis of lungs, meninges, peritonaeum, etc., Carcin-*

*oma, Sarcoma*, etc. of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic vulvar heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Examples: *Measles* (disease causing death), 29 d.s.; *Bronchopneumonia* (secondary), 10 d.s. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Con genital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "Puerperal septicæmia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent deaths state means of injury and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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RECEIVED

FEB 8 1915

BUREAU, U. S.

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## 1 PLACE OF DEATH

County Washington

1005

STATE OF MARYLAND  
CERTIFICATE OF DEATHRegistration Dist. No. 302

Village or City Hagerstown (No. 425 McDowell Dr. St.; 5th Ward)

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME Margaret Clark

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE W. 5 SINGLED;  
MARRIED;  
WIDOWED;  
OR DIVORCED  
(Write the word) Widow

## 6 DATE OF BIRTH

Feb 21, 1882  
(Month) (Day) (Year)

## 7 AGE

82 yrs. 10 mos. 24 ds. If LESS than  
1 day, \_\_\_\_\_ hrs.  
OR \_\_\_\_\_ min. ?

## 8 OCCUPATION

(a) Trade, profession, or  
particular kind of work.  
(b) General nature of industry,  
business, or establishment in  
which employed (or employer)

9 BIRTHPLACE  
(State or country)Maine10 NAME OF  
FATHERHenryfield11 BIRTHPLACE  
OF FATHER  
(State or country)N. A.12 MAIDEN NAME  
OF MOTHERBethel13 BIRTHPLACE  
OF MOTHER  
(State or country)Maine

## 14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Mrs. C. J. Thornton

(Address) 425 McDowell Dr.

## 15

Filed 1-13-1915 Henry Davis

REGISTRAR

If more blanks are needed, address State Registrar, 6 E. Franklin St., Balto., Requesting V. S. No. 1

## MEDICAL CERTIFICATE OF DEATH

## 16 DATE OF DEATH

Jan - 13, 1915  
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from

Jan - 8, 1915 to Jan - 12, 1915,

that I last saw her alive on Jan 12, 1915,

and that death occurred on the date stated above, at 8 a.m.

The CAUSE OF DEATH\* was as follows:

Exhaustion

(Duration) yrs. mos. ds.

Contributory Arterio-Sclerosis  
(Secondary)

(Duration) ? yrs. mos. ds.

(Signed) St. Lucile, M. D.  
Jan 13, 1915 (Address) Hagerstown, Md.

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

## 18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted,  
If not at place of death?

Former or  
usual residence

## DATE OF BURIAL

East Corinth, Maine Jan 16, 1915

## 20 UNDERTAKER

Kraus Bros ADDRESS Hagerstown  
Md.

# REVISED UNITED STATES STANDARD

## CERTIFICATE OF DEATH

[Approved by U. S. Census and American Public Health Association.]

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**Statement of cause of death**—Name, first, the disease causing death (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Group"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritonaeum*, etc. *Carcin-*oma, *Sarcoma*, etc., of ..... (name origin); "Can-  
cer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis* etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Con genital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Malaria," "Old Age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "Puerperal septicemia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent deaths state means of injury and quality as accidental, suicidal, or homicidal, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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RECEIVED

FEB 6 1915

BUREAU, V. S.

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1 PLACE OF DEATH		151	1006	STATE OF MARYLAND CERTIFICATE OF DEATH	
County <u>Washington</u>		134		Registration Dist. No. <u>B 06</u>	
Village or City <u>Canton</u> (No.)				St. _____ Ward _____	
2 FULL NAME <u>Silas H. Belue Jr.</u>					
PERSONAL AND STATISTICAL PARTICULARS					
3 SEX <u>Male</u>	4 COLOR OR RACE <u>White</u>	5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word)	Single		
6 DATE OF BIRTH <u>12 25</u>		(Month) <u>12</u>	(Day) <u>25</u>	(Year) <u>1914</u>	
7 AGE <u>— yrs. — mos. 16</u>		If LESS than 1 day, hrs. OR min. ?			
8 OCCUPATION (a) Trade, profession, or particular kind of work. <u>None</u>					
(b) General nature of industry, business, or establishment in which employed (or employer) <u>000</u>					
9 BIRTHPLACE (State or country) <u>Canton</u>					
10 NAME OF FATHER <u>Silas H. Belue</u>					
11 BIRTHPLACE OF FATHER (State or country) <u>Smithsburg</u>					
12 MAIDEN NAME OF MOTHER <u>Emma Stollings</u>					
13 BIRTHPLACE OF MOTHER (State or country) <u>Hallsville</u>					
14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE Informant <u>Silas H. Belue</u> (Address) <u>Canton</u>					
15 Filed <u>Jan 11, 1915</u> J. H. Ferguson REGISTRAR					
16 DATE OF DEATH <u>Jan 10, 1915</u> (Month) <u>Jan</u> (Day) <u>10</u> (Year) <u>1915</u>					
17 I HEREBY CERTIFY, That I attended deceased from <u>Jan 5, 1915</u> , to <u>Jan 10, 1915</u> , that I last saw him alive on <u>Jan 10, 1915</u> , and that death occurred on the date stated above, at <u>7 P.M.</u> , The CAUSE OF DEATH* was as follows: <u>Pneumonia</u>					
(Duration) yrs. <u>16</u> mos. <u>0</u> ds.					
Contributory (Secondary)					
(Duration) yrs. <u>0</u> mos. <u>0</u> ds.					
(Signed) <u>Monfawors</u> , M. D. Jan 11, 1915 (Address) <u>Smithsburg</u>					
*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCI- DENTAL, SUICIDAL, or HOMICIDAL.					
18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS) At place of death yrs. mos. ds. In the State yrs. mos. ds.					
Where was disease contracted, if not at place of death?					
Former or usual residence.					
19 PLACE OF BURIAL OR REMOVAL <u>Canton</u> DATE OF BURIAL <u>Jan 12th, 1915</u>					
20 UNDERTAKER <u>Gov. B. Hoover</u> ADDRESS <u>Smithsburg</u>					

# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

[Approved by U. S. Census and American Public Health Association.]

ASSOCIATION

Statement of occupation—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary foreman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples:

(a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At Home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the disease causing death, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer* (*reired 6 yrs.*). For persons who have no occupation whatever, write *None*.

**Statement of cause of death—**Name, first, the **DISEASE** causing death (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritonaeum*, etc. *Carcin-*

*oma*, *Sarcoma*, etc., of ..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), **29 ds.**; *Bronchopneumonia* (secondary), **10 ds.** Never report mere symptoms or terminal conditions, such as "Anemia," "Anæmia" (merely symptomatic), "Atrœphy," "Collapse," "Coma," "Convulsions," "Debility" ("Con genital," "Senile," etc.), "Droopy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Malaria," "Old Age," "Shock," "Tœnia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "Puerperal septicæ mia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent deaths state means of injury and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.

RECEIVED

FEB 3 1915

BUREAU, V. S.

## WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See Instructions on back of certificate.

## 1 PLACE OF DEATH

County Hanover County

Village or City Sharpsburg (No. 5)

FULL NAME Stillborn Child

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX <u>Female</u>	4 COLOR OR RACE <u>White</u>	5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word) <u>—</u>
---------------------	------------------------------	--

## 6 DATE OF BIRTH

1 16, 1915  
(Month) (Day) (Year)

7 AGE <u>Stillborn child</u>	If LESS than 1 day, hrs. yrs. <u>—</u> mos. <u>—</u> ds. OR min. ?
------------------------------	--

## 8 OCCUPATION

(a) Trade, profession, or particular kind of work —  
(b) General nature of industry, business, or establishment in which employed (or employer) —

9 BIRTHPLACE  
(State or country) Md

## PARENTS

10 NAME OF FATHER Wallin L. Cline

11 BIRTHPLACE OF FATHER  
(State or country) Md

12 MAIDEN NAME OF MOTHER Rosie Goldman

13 BIRTHPLACE OF MOTHER  
(State or country) Md

## 14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Wallin L. Cline

(Address) Sharpsburg Md

## 15

Filed 1/17/, 1915 Chas. N. Hoffmaster

REGISTRAR

1007 STATE OF MARYLAND  
CERTIFICATE OF DEATH

Registered No. 300

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

St. — Ward Cline

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH 1 16, 1915  
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from

—, 191— to —, 191—

that I last saw h. — alive on —, 191—

and that death occurred on the date stated above, at — m.

The CAUSE OF DEATH\* was as follows:

Stillborn child

(Duration) — yrs. — mos. — ds.

Contributory  
(Secondary) —

(Duration) — yrs. — mos. — ds.

(Signed) W. Howell Hardman, M. D. (Address) Sharpsburg

1/16, 191— (Address) Sharpsburg

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, OR HOMICIDAL.

## 18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death — yrs. — mos. — ds. In the State — yrs. — mos. — ds.

Where was disease contracted,  
If not at place of death?

Former or  
usual residence —

## 19 PLACE OF BURIAL OR REMOVAL

Sharpsburg, Md.

DATE OF BURIAL  
1/17th, 191—

## 20 UNDERTAKER

Albert Leaf, Half Way, Md.

ADDRESS

REVISED UNITED STATES STANDARD

CERTIFICATE OF DEATH

[Approved by U. S. Census and American Public Health

Association.

**Statement of occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*; *Physician*, *Composer*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer*, *Farm laborer*, *Laborer*—*Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the disease causing death, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer* (*retired 6 yrs.*). For persons who have no occupation whatever, write *None*.

**Statement of cause of death**—Name, first, the disease causing death (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritonacum*, etc. *Carcin-*

oma. Sarcoma, etc., of ..... (name origin; "Oancer" is less definite; avoid use of "Tumor" for malignant neoplasms); Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: Measles (disease causing death), 29 ds.; Bronchopneumonia (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Anæmia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Con-genital," "Senile," etc.), "Dropsey," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Mara-nus," "Old Age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. For VIO-LENCE DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide. The nature of the injury, as fracture of skull, and consequences (e. g., sepsis, tetanus) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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**Statement or cause of death**—Name, first, the disease causing death (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Group"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritonacum, etc.*; *Carcin-*

## WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH  
County Washington 1008  
Village or City Broadfording (No. 66)

2 FULL NAME William B. Craig

PERSONAL AND STATISTICAL PARTICULARS

3 SEX <u>Male</u>	4 COLOR OR RACE <u>White</u>	5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word) <u>Widow</u>		
6 DATE OF BIRTH <u>1832 Feb 18</u>		(Month) (Day) (Year)		
7 AGE <u>82</u>	8 yrs. <u>10</u>	9 mos. <u>26</u>	10 ds. <u>0</u>	11 If LESS than 1 day, _____ hrs. OR _____ min. ?
8 OCCUPATION (a) Trade, profession, or particular kind of work. <u>Shoemaker</u> (b) General nature of industry, business, or establishment in which employed (or employer) <u>Pensioner</u>				
9 BIRTHPLACE (State or country) <u>Gettysburg Pa</u>				
10 NAME OF FATHER <u>George Craig</u>				
11 BIRTHPLACE OF FATHER <u>Unknown</u>				
12 MAIDEN NAME OF MOTHER <u>Mary McHanley</u>				
13 BIRTHPLACE OF MOTHER <u>Unknown</u>				
14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE (Informant) <u>O. M. Richter</u> (Address) <u>Clear Spring Md.</u>				
15 Filed <u>Jan 15th 1915</u> by <u>Lesley McFadden</u> Signature <u>Lesley McFadden</u> REGISTRAR				

STATE OF MARYLAND  
CERTIFICATE OF DEATHRegistration Dist. No. 303

St. \_\_\_\_\_ Ward \_\_\_\_\_

[If death occurred in  
a hospital or institution,  
give its NAME instead  
of street and number.]

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH Jan 14, 1915  
(Month) (Day) (Year)17 I HEREBY CERTIFY, That I attended deceased from  
Sept 12, 1914, to Aug 14, 1914,that I last saw him alive on Aug 14, 1914,  
and that death occurred on the date stated above, at 6:30 P.M.

The CAUSE OF DEATH\* was as follows:

I do not know the precise  
cause of death. He had been plagued  
at the time of death by a  
feverish condition.  
He died from natural causes.

Contributory  
Secondary18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS,  
OR RECENT RESIDENTS)  
(Signed) Harry B. Chapman, M. D.  
Jan 15, 1915 (Address) Greenvale Pa R.R. 5\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT  
CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCI-  
DENTAL, SUICIDAL, or HOMICIDAL.

At place \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds. In the \_\_\_\_\_  
of death \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds. State \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds  
Where was disease contracted,  
If not at place of death? \_\_\_\_\_  
Former or  
usual residence \_\_\_\_\_

19 PLACE OF BURIAL OR REMOVAL Broadfording DATE OF BURIAL  
Jan 16th 1915  
20 UNDERTAKER Frantz Bros ADDRESS Clear Spring Md.

If more blanks are needed, address State Registrar, 6 E. Franklin St., Baltimore, Requesting V. S. No. 1.

# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

[Approved by U. S. Census and American Public Health Association.]

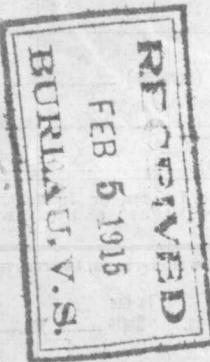
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(a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At Home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the disease causing death, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.)*. For persons who have no occupation whatever, write *None*.

**Statement of cause of death**—Name, first, the disease causing death (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritonaeum, etc.*, *Carcin-*

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If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.



## WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

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1 PLACE OF DEATH  
County Washington

Village or City Hagerstown (No. 847) Street Cedar

2 FULL NAME Infant Deller

1009

STATE OF MARYLAND  
CERTIFICATE OF DEATHRegistered No. 302St. 2nd Ward)

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX 2 4 COLOR OR RACE White 5 SINGLE,  
MARRIED,  
WIDOWED,  
OR DIVORCED  
(Write the word) Single

6 DATE OF BIRTH Jan 12, 1915  
(Month) (Day) (Year)

7 AGE — yrs. — mos. — ds. IF LESS than  
1 day, — hrs.  
OR — min. ?

8 OCCUPATION  
(a) Trade, profession, or  
particular kind of work. —  
(b) General nature of industry,  
business, or establishment in  
which employed (or employer) —

9 BIRTHPLACE  
(State or country) Hagerstown, Md.

10 NAME OF  
FATHER W. M. Morris

11 BIRTHPLACE  
OF FATHER  
(State or country) Daisy Deller

12 MAIDEN NAME  
OF MOTHER Daisy Crim

13 BIRTHPLACE  
OF MOTHER  
(State or country) Martinsburg, W. Va.

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

Informant Daisy Deller  
(Address) 847 Cedar St. Hagerstown

15 Filed 1/25/15 Henry Davis  
REGISTRAR

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH Jan 12, 1915  
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from

—, 191—, to —, 191—

that I last saw h. — alive on —, 191—

and that death occurred on the date stated above, at — m.

The CAUSE OF DEATH\* was as follows:

Miscarriage (Prob 2 mo  
gestation) Still Born

(Duration) — yrs. — mos. — ds.

Contributory  
(Secondary) —  
(Duration) — yrs. — mos. — ds.

(Signed) W. M. Morris, M. D.

1/25/15 (Address) Grey Gables Hagerstown

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death — yrs. — mos. — ds. In the State — yrs. — mos. — ds.

Where was disease contracted, —  
If not at place of death? —

Former or usual residence 847 Cedar St. Hagerstown, Md.

19 PLACE OF BURIAL OR REMOVAL DATE OF BURIAL  
—, 191—

20 UNDERTAKER ADDRESS  
No Undertaker —

# REVISED UNITED STATES STANDARD

## CERTIFICATE OF DEATH

[Approved by U. S. Census and American Public Health Association.]

**Statement of occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Composer*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary foreman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the disease causing death, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer* (*retired 6 yrs.*). For persons who have no occupation whatever, write *None*.

**Statement of cause of death**—Name, first, the disease causing death (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Group"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritonaeum*, etc. *Carcinoma*, *Sarcoma*, etc., of ..... (name origin); "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic tubular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Examples: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthma," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Con genital"), "Smile," etc., "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Mastitis," "Old Age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "Puerperal septicemia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent deaths state means of injury and quality as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.

RECEIVED

FEB 6 1915

BUREAU, V. S.

## WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH County <u>Washington</u> 1010 Village or City <u>Hagerstown</u> (No. 205, Frederick)		STATE OF MARYLAND CERTIFICATE OF DEATH Registration Dist. No. 302	
		St. 3 Ward)	
[If death occurred in a hospital or institution, give its NAME instead of street and number.]			
2 FULL NAME <u>Ronland Davis</u>			
PERSONAL AND STATISTICAL PARTICULARS			
3 SEX <u>male</u>	4 COLOR OR RACE <u>white</u>	5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word) <u>Married</u>	MEDICAL CERTIFICATE OF DEATH
6 DATE OF BIRTH <u>Oct 31</u>	(Month) <u>1854</u>	16 DATE OF DEATH <u>Jan 31</u>	
7 AGE <u>60 yrs. 3 mos. —</u>	If LESS than 1 day, hrs. OR min. ?	(Month) <u>1915</u>	
8 OCCUPATION (a) Trade, profession, or particular kind of work. <u>Miner</u>	I HEREBY CERTIFY, That I attended deceased from <u>Jan 10<sup>th</sup></u> , 1915, to <u>Jan 30</u> , 1915, that I last saw him alive on <u>Jan 30</u> , 1915, and that death occurred on the date stated above, at <u>6:15</u> a.m.		
9 BIRTHPLACE (State or country) <u>Wales</u>	The CAUSE OF DEATH* was as follows: <u>Fracture of right hip</u> <u>Tall</u> <u>763</u> (Duration) <u>6</u> yrs. <u>6</u> mos. <u>0</u> ds.		
10 NAME OF FATHER <u>John Davis</u>	Contributory Secondary		
11 BIRTHPLACE OF FATHER (State or country) <u>Wales</u>	Complications		
12 MAIDEN NAME OF MOTHER <u>Mary Oliver</u>	(Duration) <u>0</u> yrs. <u>0</u> mos. <u>0</u> ds.		
13 BIRTHPLACE OF MOTHER (State or country) <u>Wales</u>	(Signed) <u>Daniel A. Watkins</u> , M. D. (Address) <u>Hagerstown Md.</u>		
14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE (Informant) <u>John Davis</u> (Address) <u>Hagerstown Md.</u>	*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.		
15 Filed <u>2-1-5</u> Henry Davis REGISTRAR	18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS) At place _____ yrs. _____ mos. _____ ds. In the State _____ yrs. _____ mos. _____ ds Where was disease contracted, if not at place of death? Former or usual residence.		
16	19 PLACE OF BURIAL OR REMOVAL <u>Rose Hill</u> DATE OF BURIAL _____, 191_____		
20 UNDERTAKER <u>Watkins &amp; Minnoch</u>	ADDRESS <u>Hag Md.</u>		

# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

[Approved by U. S. Census and American Public Health Association.]

**Statement of occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter*, *Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary foreman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worker on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the disease causing death, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.)* For persons who have no occupation whatever, write *None*.

**Statement of cause of death**—Name, first, the disease causing death (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Group"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritonaeum*, etc., *Carcin-*

*oma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Afflentia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marrasmus," "Old Age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "Puerperal septicæmia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent deaths state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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RECEIVED

FEB 6 1915

BUREAU, V.S.

## WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

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1 PLACE OF DEATH  
County Washington

Village or City Hagerstown (No. 305, A Locust

1011 STATE OF MARYLAND  
CERTIFICATE OF DEATH

Registration Dist. No. 302

19

St. 4 Ward)

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME Charles E. Davis

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX male 4 COLOR OR RACE white 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED MARRIED (Write the word)

## 6 DATE OF BIRTH

May 18, 1875  
(Month) (Day) (Year)

## 7 AGE

39 yrs. 7 mos. 19 ds.

If LESS than  
1 day, .... hrs.  
OR ..... min. ?

## 8 OCCUPATION

(a) Trade, profession, or  
particular kind of work. Clerk  
(b) General nature of industry,  
business, or establishment in  
which employed (or employer) Retired

## 9 BIRTHPLACE

(State or country) Md

## 10 NAME OF FATHER

Wm Davis

## 11 BIRTHPLACE OF FATHER

Md

## 12 MAIDEN NAME OF MOTHER

Alice Crayton

## 13 BIRTHPLACE OF MOTHER

Md

## 14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Geo M. Markell

(Address) Hagerstown Md.

## 15

Filed 1/9-1915 Harry Davis

REGISTRAR

## MEDICAL CERTIFICATE OF DEATH

## 16 DATE OF DEATH

1 8, 1915  
(Month) (Day) (Year)

I HEREBY CERTIFY, That I attended deceased from July 1, 1914 to Aug 8, 1915  
that I last saw him alive on Dec 12, 1915

and that death occurred on the date stated above, at 3:30 P.M.

The CAUSE OF DEATH\* was as follows:

Organic brain disease  
Post mortem

(Duration) 0 yrs. 8 mos. 0 ds.

Contributory  
Secondary

Acute delirium  
of heart

(Duration) 1 yrs. 0 mos. 0 ds.

(Signed) W. E. Scott, M. D.

1/9, 1915 (Address) Hagerstown

State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

## 18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death 0 yrs. 0 mos. 0 ds. In the State 0 yrs. 0 mos. 0 ds

Where was disease contracted,  
If not at place of death?

Former or  
usual residence.

## 19 PLACE OF BURIAL OR REMOVAL

Rose Hill

## DATE OF BURIAL

1/11, 1915

## 20 UNDERTAKER

Watkins & Minich

## ADDRESS

Hagerstown Md.

# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

[Approved by U. S. Census and American Public Health Association.]

**Statement of occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age.

For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples:

(a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer*, *Farm laborer*, *Laborer*—*Cotton mill*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At Home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housmaid*, etc. If the occupation has been changed or given up on account of the disease causing death, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer* (*retired 6 yrs.*) For persons who have no occupation whatever, write *None*.

## Statement of cause of death

Name, first, the disease causing death (the primary affection with respect to time and causation), using always the same accepted

term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Group"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritonaeum, etc.*, *Carcin-*

*oma*, *Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor", for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Examples: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Anæmia," "Anæmia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsey," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "Puerperal septicæmia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent deaths state means of injury and quality as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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RECEIVED

FEB 6 1915

BUREAU U. S.

## MARGIN RESERVED FOR BINDING

## WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

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1 PLACE OF DEATH  
County Washington

Village or City Brown Creek (No. \_\_\_\_\_)

1012

STATE OF MARYLAND  
CERTIFICATE OF DEATHRegistration Dist. No. 305

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME Ena Frances Detrow

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE white 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED Singl's  
(Write the word)

6 DATE OF BIRTH January 11, 1915  
(Month) (Day) (Year)

7 AGE     X    X IF LESS than  
yrs. mos. ds. 1 day, hrs.  
OR min. ?

8 OCCUPATION  
(a) Trade, profession, or  
particular kind of work. None  
(b) General nature of industry,  
business, or establishment in  
which employed (or employer)

9 BIRTHPLACE  
(State or country) Maryland

10 NAME OF  
FATHER Clarence Detrow

11 BIRTHPLACE  
OF FATHER  
(State or country) Brown Creek Md

12 MAIDEN NAME  
OF MOTHER Cora Ford

13 BIRTHPLACE  
OF MOTHER  
(State or country) Maryland

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE  
(Informant) Clarence Detrow

(Address) Reader Creek Md

15 Filed Jan 12, 1915 Geo. M. Stover, J. P.

REGISTRAR

152

134

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH January 11, 1915  
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from  
January 11, 1915 to January 11, 1915

that I last saw h. En alive on January 11, 1915  
and that death occurred on the date stated above, at 11:50 m.

The CAUSE OF DEATH\* was as follows:  
Prolonged birth

Contributory Cardiac Failure  
Secondary     X    X yrs. mos. ds.

(Duration)     X    X yrs. mos. ds.  
(Signed) J. M. Wagaman, M. D.

Jan. 12, 1915 (Address) Hagerstown, Md

\* State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS,  
OR RECENT RESIDENTS)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted,  
If not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL Reader Creek Cemetery DATE OF BURIAL Jan 12, 1915

20 UNDERTAKER Wm F. Baat ADDRESS Baltimore, Md

# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

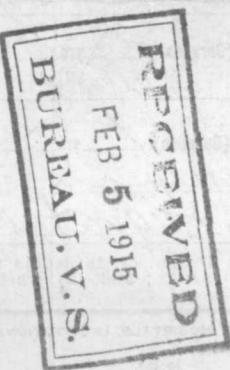
[Approved by U. S. Census and American Public Health Association.]

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**Statement of cause of death**—Name, first, the disease causing death (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Group"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum, etc., Carcin-*

*oma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 d.; *Bronchopneumonia* (secondary), 10 d. Never report mere symptoms or terminal conditions, such as "Anemia," "Anæmia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. For violent deaths state means of injury and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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## WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

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1 PLACE OF DEATH  
County Washington

Village or City Dry Run (No. ....)

1013 STATE OF MARYLAND  
CERTIFICATE OF DEATH

Registration Dist. No. 303

St.: Ward)

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME Minnie May Dickerhoof

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX female 4 COLOR OR RACE white 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED Single  
(Write the word)

6 DATE OF BIRTH

Nov 9, 1914  
(Month) (Day) (Year)

7 AGE

2 yrs. 2 mos. 19 ds.

IF LESS than  
1 day, \_\_\_\_ hrs.  
OR \_\_\_\_ min. ?

8 OCCUPATION

(a) Trade, profession, or particular kind of work.  
(b) General nature of industry, business, or establishment in which employed (or employer)

9 BIRTHPLACE

(State or country)

PARENTS

10 NAME OF FATHER

Thomas Clinton Dickerhoof

11 BIRTHPLACE OF FATHER

(State or country)

Maryland

12 MAIDEN NAME OF MOTHER

Florence Palsgrove

13 BIRTHPLACE OF MOTHER

(State or country)

Wash Co. Md.

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Thos. C. Dickerhoof

(Address)

Clearspring Md.

15

Filed Jan 28, 1915 David H. Miller

REGISTRAR

89

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

January 28th, 1915  
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from

, 191..., to , 191...,

that I last saw h. alive on , 191...,

and that death occurred on the date stated above, at m.,

The CAUSE OF DEATH\* was as follows:

Unknown - had a bad cold for several days  
(Duration) yrs. mos. ds.

Contributory  
Secondary

(Signed) David H. Miller, Coroner, M. D.  
(Address) Clearspring, Md.  
Jan 28, 1915

\* State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, OR HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place yrs. mos. ds. In the State yrs. mos. ds

Where was disease contracted,  
If not at place of death?

Former or  
usual residence

19 PLACE OF BURIAL OR REMOVAL DATE OF BURIAL  
Blair Valley Rd., Jan 29, 1915

20 UNDERTAKER ADDRESS  
Frautz Bros. & Co., Clear Spring

# REVISED UNITED STATES STANDARD

## CERTIFICATE OF DEATH

[Approved by U. S. Census and American Public Health Association.]

**Statement of occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework, or At Home*, and children, not gainfully employed, as *At school or At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid, etc.* If the occupation has been changed or given up on account of the disease causing death, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.)* For persons who have no occupation whatever, write *None*.

**Statement of cause of death**—Name, first, the disease causing death (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritonacum, etc., Cancer-*

*oma, Sarcoma, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Examples: Measles (disease causing death), 29 ds.; Bronchomegaly (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Anemia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "Puerperal septicemia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent deaths state means of INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide. The nature of the injury, as fracture of skull, and consequences (e. g., sepsis, tetanus) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)*

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.

R

FEB 5 1915

BUREAU, U. S.

## WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH  
County Washington

Village or City Halfway (No. 24th Elect Dist.)

1014

STATE OF MARYLAND  
CERTIFICATE OF DEATHRegistration Dist. No. 302St. 1 Ward)

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME Jacob Eckstine

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX male 4 COLOR OR RACE white 5 SINGLE,  
MARRIED,  
WIDOWED,  
OR DIVORCED  
(Write the word) Married

6 DATE OF BIRTH July 24  
(Month) (Day) (Year) , 1841

7 AGE 73 yrs. 5 mos. 29 ds. If LESS than  
1 day, \_\_\_\_\_ hrs.  
OR \_\_\_\_\_ min. ?

## 8 OCCUPATION

(a) Trade, profession, or  
particular kind of work farmer  
(b) General nature of industry,  
business, or establishment in  
which employed (or employer)

9 BIRTHPLACE  
(State or country) Md

10 NAME OF  
FATHER John Eckstine

11 BIRTHPLACE  
OF FATHER  
(State or country) Germany

12 MAIDEN NAME  
OF MOTHER Katherine Lundy

13 BIRTHPLACE  
OF MOTHER  
(State or country) Md

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Martin Startzman

(Address) Hagerstown Md

15

Filed 1-23-1915 Kenny Davis

REGISTRAR

(81)

STATE OF MARYLAND  
CERTIFICATE OF DEATH

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH January 23  
(Month) (Day) (Year) , 1915

17 I HEREBY CERTIFY, That I attended deceased from  
Dec 21, 1914, to January 23, 1915

that I last saw him alive on January 22, 1915

and that death occurred on the date stated above, at 605 a.m.

The CAUSE OF DEATH\* was as follows:

General Paroxysmic Sclerosis  
Fibro Myocardiitis

Contributory None  
Secondary Cardiac Failure

(Duration) X yrs. 1 mos. 2 ds.

(Signed) M. M. Wagaman, M. D.  
Jan 23, 1915 (Address) Hagerstown Md

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds. In the  
of death \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds. State \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds

Where was disease contracted,  
If not at place of death?

Former or  
usual residence

19 PLACE OF BURIAL OR REMOVAL Rose Hill DATE OF BURIAL 1/25-1915

20 UNDERTAKER Walters & Minich ADDRESS Hag. Md

REVISED UNITED STATES STANDARD  
CERTIFICATE OF DEATH

[Approved by U. S. Census and American Public Health

### ASSOCIATION.]

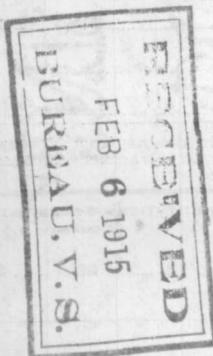
**Statement of occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age.

for many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer*, *Farm laborer*, *Laborer*—*Cobbler*, etc. Women at home, who are engaged in duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At Home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the disease causing death, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.)* For persons who have no occupation whatever, write *None*.

oma, Sarcoma, etc. of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Menstrus*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 d.s.; *Bronchopneumonia* (secondary), 10 d.s. Never report mere symptoms or terminal conditions, such as "Anæmia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "Puerperal septicæmia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent deaths state means of injury and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.

**Statement of cause of death**—Name, first, the disease causing death (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritonaeum, etc., Cancer-*



## WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

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## 1 PLACE OF DEATH

County Washington

1015

STATE OF MARYLAND  
CERTIFICATE OF DEATHRegistration Dist. No. 302St. 4th Ward

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

## 2 FULL NAME

Everly

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX <u>Female</u>	4 COLOR OR RACE <u>White</u>	5 SINGLE, MARRIED, WIDOWED, OR DIVORCED <u>Infant</u> (Write the word)
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## 6 DATE OF BIRTH

Jan 6, 1915  
(Month) (Day) (Year)

## 7 AGE

yrs. — mos. — ds. If LESS than  
1 day, \_\_\_\_ hrs.  
OR \_\_\_\_ min. ?

## 8 OCCUPATION

(a) Trade, profession, or particular kind of work  
\_\_\_\_

(b) General nature of industry, business, or establishment in which employed (or employer)  
\_\_\_\_

9 BIRTHPLACE  
(State or country)W.H.

## 10 NAME OF FATHER

Albert G. Everly11 BIRTHPLACE OF FATHER  
(State or country)W.H.

## 12 MAIDEN NAME OF MOTHER

Hella Armstrong13 BIRTHPLACE OF MOTHER  
(State or country)W.H.

## 14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Albert G. Everly

(Address)

Hagerstown MD

## 15

Jan 6, 1915 Henry Davis

REGISTRAR

If more blanks are needed, address State Registrar, 6 E. Franklin St., Balto., Requesting V. S. No. 1.

## MEDICAL CERTIFICATE OF DEATH

## 16 DATE OF DEATH

Jan 6, 1915  
(Month) (Day) (Year)

## 17 I HEREBY CERTIFY, That I attended deceased from

Jan 6, 1915 to Jan 6, 1915,  
that I last saw him alive on Bratton, 1915.and that death occurred on the date stated above, at 5 a.m.,  
The CAUSE OF DEATH\* was as follows:Promoting birth at  
5 months

(Duration) yrs. mos. ds.

Contributory  
(Secondary)(Still-Born)

(Duration) yrs. mos. ds.

(Signed) 1/6, 1915 (Address) Hagerstown, M. D.

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

## 18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted,  
if not at place of death?Former or  
usual residence.

## 19 PLACE OF BURIAL OR REMOVAL

Rose Hill Cemetery

## DATE OF BURIAL

Jan 7, 1915

## 20 UNDERTAKER

Kraus Bros

## ADDRESS

Hagerstown  
W.H.

# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

[Approved by U. S. Census and American Public Health Association.]

**Statement of occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At Home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the disease causing death, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer* (*retired 6 yrs.*). For persons who have no occupation whatever, write *None*.

## Statement of cause of death

Name, first, the disease causing death (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Group"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritonaeum*, etc., *Carcin-*

oma

*Sarcoma*, etc., of ..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis* etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Con genital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old. Age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "Puerperal septicæmia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent deaths state means of injury and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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RECEIVED

FEB 6 1915

BUREAU, V.S.

## WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

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1 PLACE OF DEATH  
County Washington

Village or City Hagerstown (No. 27, Broadway St., 4th Ward)

2 FULL NAME Emma Jane EyerlySTATE OF MARYLAND  
CERTIFICATE OF DEATHRegistration Dist. No. 302

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE White 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED Widowed  
(Write the word)

6 DATE OF BIRTH July 10, 1898  
(Month) (Day) (Year)

7 AGE 75 yrs. 6 mos. 7 ds. If LESS than 1 day, \_\_\_\_ hrs. OR min. ?

8 OCCUPATION  
(a) Trade, profession, or particular kind of work. Housewife  
(b) General nature of industry, business, or establishment in which employed (or employer)

9 BIRTHPLACE Maryland  
(State or country)

10 NAME OF FATHER Samuel Wiener

11 BIRTHPLACE OF FATHER Pa.  
(State or country)

12 MAIDEN NAME OF MOTHER Susan Newcomer

13 BIRTHPLACE OF MOTHER Maryland  
(State or country)

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) My B. A. Brownie

(Address) Hagerstown, Md.

15 Filed 1/18/18, 1915 Henry Davis

REGISTRAR

If more blanks are needed, address State Registrar, 6 E. Franklin St., Balto., Requesting V. S. No. 1.

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH Jan 17, 1915  
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from Jan 3rd, 1915, to Jan 17, 1915,

that I last saw her alive on Jan 17, 1915,

and that death occurred on the date stated above, at 2:40 P.M.

The CAUSE OF DEATH\* was as follows:

Chronic bronchitis  
Chronic nephritis

(Duration) 28 yrs. mos. ds.

Contributory Secondary  
(Duration) 28 yrs. mos. ds.

(Signed) John Miller Jr., M. D.  
(Address) Hagerstown

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death 117, 1915 yrs. mos. ds. In the State 117, 1915 yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence.

19 PLACE OF BURIAL OR REMOVAL St. Paul's Church DATE OF BURIAL Jan 19, 1915

20 UNDERTAKER A. K. Coffman ADDRESS Hagerstown

(1)

# REVISED UNITED STATES STANDARD

## CERTIFICATE OF DEATH

[Approved by U. S. Census and American Public Health Association.]

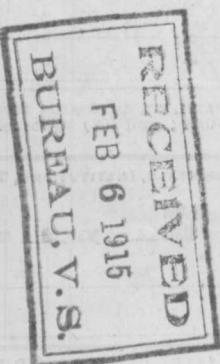
**Statement of occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples:

(a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc. without more precise specification as *Day laborer*, *Farm laborer*, *Laborer*—*Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At Home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the disease causing death, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer* (*retired 6 yrs.*) For persons who have no occupation whatever, write *None*.

**Statement of cause of death**—Name, first, the disease causing death (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritonaeum*, etc., *Carcin-*

*oma*, *Sarcoma*, etc., of..... (name origin); "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 d.; *Bronchopneumonia* (secondary), 10 d. Never report mere symptoms or terminal conditions, such as "Anæmia," "Anæmia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. For violent deaths state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.



## WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

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1 PLACE OF DEATH  
County Washington

Village or City Hagerstown (No. 17, H. Street St., 3rd Ward)

## 2 FULL NAME

1017 STATE OF MARYLAND  
CERTIFICATE OF DEATH  
Registration Dist. No. 302

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

Jeff Forward

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX M 4 COLOR OR RACE White 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED Single  
(Write the word)

## 6 DATE OF BIRTH

1 21, 1915  
(Month) (Day) (Year)

7 AGE Not born If LESS than  
yrs. mos. ds. 1 day, hrs. OR min. ?

## 8 OCCUPATION

(a) Trade, profession, or  
particular kind of work.

None

(b) General nature of industry,  
business, or establishment in  
which employed (or employer)

None

9 BIRTHPLACE  
(State or country)

Washington County Md

10 NAME OF  
FATHER

Not known

11 BIRTHPLACE  
OF FATHER  
(State or country)12 MAIDEN NAME  
OF MOTHER

Mary Forward

13 BIRTHPLACE  
OF MOTHER  
(State or country)

Pa.

## 14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) A. D. Campbell

(Address) Hagerstown Md

## 15

Filed 1/23, 1915 Henry Davis

REGISTRAR

## MEDICAL CERTIFICATE OF DEATH

## 16 DATE OF DEATH

1 21, 1915  
(Month) (Day) (Year)

## 17 I HEREBY CERTIFY, That I attended deceased from

, 191..., to , 191...,

that I last saw h. alive on , 191...,

and that death occurred on the date stated above, at m.,

The CAUSE OF DEATH\* was as follows:

Jeff Boy Infant  
4 mos gestation  
(Duration) yrs. mos. ds.

Contributory  
Secondary

(Duration) yrs. mos. ds.  
(Signed) A. D. Campbell, M. D.  
January 24, 1915 (Address) Hagerstown Md

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, OR HOMICIDAL.

## 18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place yrs. mos. ds. In the  
of death yrs. mos. ds. State yrs. mos. ds.

Where was disease contracted,  
If not at place of death?

Former or  
usual residence

## 19 PLACE OF BURIAL OR REMOVAL

No permit issued

DATE OF BURIAL  
, 191...

## 20 UNDERTAKER

ADDRESS

# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

[Approved by U. S. Census and American Public Health Association.]

**Statement of occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter*, *Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Houswife*, *Housework*, or *At Home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the disease causing death, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.)* For persons who have no occupation whatever, write *None*.

**Statement of cause of death**—Name, first, the disease causing death (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Group"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritonaeum*, etc., *Carcin-*

*oma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Examples: *Measles* (disease causing death), 29 d.; *Bronchopneumonia* (secondary), 10 d. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. For violent deaths state means of INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sensis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.

RECEIVED

FEB 6 1915

BUREAU, V.S.

## WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH  
County Washington

V  
15  
Village or City Hagerstown (No. 17, Procust St., 3rd Ward)

2 FULL NAME  
Milt Forward

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX M 4 COLOR OR RACE White 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word) Singer

6 DATE OF BIRTH 1 21, 1903  
(Month) (Day) (Year)

7 AGE 100 Born If LESS than 1 day, hrs. OR min. ?  
.... yrs. .... mos. .... ds.

8 OCCUPATION  
(a) Trade, profession, or particular kind of work. None  
(b) General nature of industry, business, or establishment in which employed (or employer) None

9 BIRTHPLACE  
(State or country) Washington C. Md.

10 NAME OF FATHER Not obtained

11 BIRTHPLACE OF FATHER  
(State or country) Pa.

12 MAIDEN NAME OF MOTHER Maud Forward

13 BIRTHPLACE OF MOTHER  
(State or country) Pa.

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE  
(Informant) H. W. Davis M.D.

(Address) Hagerstown Md.

15 Filed 1/23, 1915 Henry Davis  
REGISTRAR

1018 STATE OF MARYLAND  
CERTIFICATE OF DEATHRegistration Dist. No. 302

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH 1 21, 1915  
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from  
....., 191..., to ..... 191...,

that I last saw h..... alive on ..... 191...,

and that death occurred on the date stated above, at ..... m.,

The CAUSE OF DEATH\* was as follows:

Not Born  
4 mos. gestation

(Duration) .... yrs. .... mos. .... ds.

Contributory  
Secondary

(Duration) .... yrs. .... mos. .... ds.

(Signed) H. W. Davis M.D. M. D.  
....., 1915 (Address) Hagerstown Md.

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death .... yrs. .... mos. .... ds. In the State .... yrs. .... mos. .... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL No permit issued DATE OF BURIAL ..... 191...

20 UNDERTAKER ADDRESS

# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

[Approved by U. S. Census and American Public Health Association.]

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**Statement of cause of death**—Name, first, the disease causing death (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Group"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritonaeum*, etc., *Carcinoma*, *Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Examples: *Measles* (disease causing death), 29 d.; *Bronchopneumonia* (secondary), 10 d. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Malaria," "Old Age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "Puerperal septicæmia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent deaths state means of injury and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDE, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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FEB 6 1915

BUREAU, V.S.

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## 1 PLACE OF DEATH

County Washington

Village or City Near Williamsport

(No.)

along C & O. canal

1019

STATE OF MARYLAND  
CERTIFICATE OF DEATH

Registration Dist. No. 301

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

## 2 FULL NAME

Mary A Fultz

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE White 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED Mamed  
(Write the word)

6 DATE OF BIRTH Nov 13 1887  
(Month) (Day) (Year)

7 AGE 17 yrs. 2 mos. 13 ds. If LESS than 1 day, hrs. OR min. ?

8 OCCUPATION Housewife  
(a) Trade, profession, or particular kind of work  
(b) General nature of industry, business, or establishment in which employed (or employer) 11

9 BIRTHPLACE Maryland  
(State or country)

10 NAME OF FATHER James Bonghof

11 BIRTHPLACE OF FATHER Maryland  
(State or country)

12 MAIDEN NAME OF MOTHER Merle Myers

13 BIRTHPLACE OF MOTHER Maryland  
(State or country)

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) James Bonghof

(Address) Williamsport Md

15 Filed Jan. 28, 1915 by C. E. Rickard

Local REGISTRAR

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH January 26  
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from Jan 25, 1915 to Jan 26, 1915, that I last saw her alive on Jan 26, 1915, and that death occurred on the date stated above, at 2:30 P.M., The CAUSE OF DEATH\* was as follows:

Perforated Alveolaria

(Duration) yrs. mos. 2 ds.  
Contributory Convulsion  
Secondary

(Signed) C. E. Rickard, M. D.  
(Address) Williamsport Md  
(Duration) yrs. mos. 1/2 ds.

\* State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

## 18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, If not at place of death?

Former or usual residence.

19 PLACE OF BURIAL OR REMOVAL Williamsport Md DATE OF BURIAL Jan 28, 1915

20 UNDERTAKER L W Krebs ADDRESS Williamsport

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(a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer*, *Farm laborer*, *Laborer*—*Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At Home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the disease causing death, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer* (*retired 6 yrs.*) For persons who have no occupation whatever, write *None*.

**Statement of cause of death**—Name, first, the disease causing death (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Group"); <sup>3</sup>*Typhoid* fever (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritonaeum, etc.*, *Carcinoma*, *Sarcoma*, etc., of..... (name origin); "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 d.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Tetraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. For violent deaths state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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## MARGIN RESERVED FOR BINDING

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1 PLACE OF DEATH		1020	
County <u>Washington</u>		(64)	
Village or City <u>Hagerstown</u> (No. <u>519</u> , <u>W. Washington St.</u> ; <u>3<sup>rd</sup> Ward</u> )		STATE OF MARYLAND CERTIFICATE OF DEATH	
2 FULL NAME <u>Catherine Geary.</u>		Registration Dist. No. <u>302</u>	
[If death occurred in a hospital or institution, give its NAME instead of street and number.]			
PERSONAL AND STATISTICAL PARTICULARS			
3 SEX <u>Female</u>	4 COLOR OR RACE <u>white</u>	5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word)	<u>widow</u>
6 DATE OF BIRTH <u>Feb. 28</u>		(Month) (Day) (Year)	
7 AGE <u>77 yrs. 10 mos. 29 ds.</u>		IF LESS than 1 day, .... hrs. OR min. ?	
8 OCCUPATION <u>Housewife</u>		(Duration) yrs. mos. ds.	
(a) Trade, profession, or particular kind of work.  (b) General nature of industry, business, or establishment in which employed (or employer) <u>11</u>		Contributory Secondary	
9 BIRTHPLACE (State or country) <u>Ireland.</u>		Valvular Heart Insufficiency (Information from her regular physician)	
10 NAME OF FATHER <u>Martin Sullivan</u>		(Duration) 2 yrs. mos. ds.	
11 BIRTHPLACE OF FATHER (State or country) <u>Ireland.</u>		(Signed) <u>The Kress by</u> , M. D.	
12 MAIDEN NAME OF MOTHER <u>Mary Kavanaugh</u>		Jan. 29, 1915 (Address) <u>Hagerstown Md.</u>	
13 BIRTHPLACE OF MOTHER (State or country) <u>Ireland.</u>		*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.	
14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE			
(Informant) <u>W. E. Geary</u>		15 PLACE OF BURIAL OR REMOVAL <u>Rose Hill Cemetery</u> DATE OF BURIAL <u>Feb. 29, 1915</u>	
(Address) <u>Hagerstown, Md.</u>		20 UNDERTAKER <u>Walter E. Davis</u> ADDRESS <u>Hagerstown, Md.</u>	
16 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)			
At place of death yrs. mos. ds.		In the State yrs. mos. ds.	
Where was disease contracted, if not at place of death?			
Former or usual residence			
17 MEDICAL CERTIFICATE OF DEATH		18 DATE OF DEATH <u>Jan. 27</u> (Month) (Day) (Year)	
I HEREBY CERTIFY, That I attended deceased from <u>Jan. 27</u> 1915, to <u>Jan. 27</u> 1915, that I last saw her alive on <u>Jan. 27</u> , 1915, and that death occurred on the date stated above, at <u>Hagerstown</u> .			
The CAUSE OF DEATH* was as follows:			
<u>terbral Hemorrhage - Cerebral - Instant -</u>			

# REVISED UNITED STATES STANDARD

## CERTIFICATE OF DEATH

[Approved by U. S. Census and American Public Health Association.]

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**Statement of cause of death**—Name, first, the disease causing death (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Group"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia", unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritonaeum*, etc., *Carcin-*

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BUREAU, V.S.

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## 1 PLACE OF DEATH

County WashingtonVillage or City near Smithsburg (No.)

1021

STATE OF MARYLAND  
CERTIFICATE OF DEATHRegistration Dist. No. 306St. Ward)

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

(63)

## 2 FULL NAME

Nancy Geiser

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 COLOR OR RACE

5 SINGLE,  
MARRIED,  
WIDOWED,  
OR DIVORCED  
(Write the word)

Single

6 DATE OF BIRTH

1 1, 1887  
(Month) (Day) (Year)

7 AGE

78 yrs. - mos. 1 ds.If LESS than  
1 day, .... hrs.  
OR .... min. ?

## 8 OCCUPATION

(a) Trade, profession, or  
particular kind of work.(b) General nature of industry,  
business, or establishment in  
which employed (or employer)None9 BIRTHPLACE  
(State or country)near Smithsburg

## PARENTS

10 NAME OF  
FATHERJohn Geiser11 BIRTHPLACE  
OF FATHER  
(State or country)Lancaster Pa.12 MAIDEN NAME  
OF MOTHERMary Senger13 BIRTHPLACE  
OF MOTHER  
(State or country)Lancaster Pa.

## 14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Nancy Geiser

(Address)

Smithsburg

15

Filed Jan 2, 1915J. H. Ferguson

REGISTRAR

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

Jan 2<sup>nd</sup>, 1915  
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from

....., 1911, to Dec, 1914.that I last saw her alive on Dec 30<sup>th</sup>, 1914.and that death occurred on the date stated above, at 8:30 a.m.

The CAUSE OF DEATH\* was as follows:

Progressive Muscular Atrophy(Duration) 5 yrs. mos. ds.Contributory  
(Secondary)

(Duration) yrs. mos. ds.

(Signed) Joseph Prochnau, M.D.  
Jan 2, 1915 (Address) Smithsburg, Md.

\* State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or  
usual residence

19 PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

Heights Cemetery Jan 4<sup>th</sup>, 1915

20 UNDERTAKER

Geo. B. Hooper Smithsburg

ADDRESS

REVISED UNITED STATES STANDARD  
CERTIFICATE OF DEATH

[Approved by U. S. Census and American Public Health

## Association.]

**Statement of occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At Home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the disease causing death, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.)*. For persons who have no occupation whatever, write *None*.

*oma. Surooma, etc., of* **uter** *is less definite; avoid use of "Tumor" for malignant neoplasms); Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Examples: Measles (disease causing death), 29 **d.s.**; Bronchopneumonia (secondary), 10 **d.s.** Never report mere symptoms or terminal conditions, such as "Anæmia," "Anaæmia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Con genital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Malaria," "Old Age," "Shock," "Uraæmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL septicæ mia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. For violent deaths state means of INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide. The nature of the injury, as fracture of skull, and consequences (e. g., sepsis, tetanus) may be stated under the head of "Contributory." (Recommendations on statement of cause or death approved by Committee on Nomenclature of the American Medical Association.)*

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.

**Statement of cause of death**—Name, first, the disease, time and causation, using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Group"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritonaeum, etc.*; *Carcinoma*.



## WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

## 1 PLACE OF DEATH

County WashingtonVillage or City Hagerstown (No.)1022 STATE OF MARYLAND  
CERTIFICATE OF DEATHRegistration Dist. No. 302St. — Ward —

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

## 2 FULL NAME

Russell D. Gilbert

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 COLOR OR RACE

5 SINGLE,  
MARRIED,  
WIDOWED,  
OR DIVORCED  
(Write the word)

6 DATE OF BIRTH

Nov 2, 1835  
(Month) (Day) (Year)

7 AGE

79 yrs. 2 mos. 9 ds. If LESS than  
1 day, hrs. OR min. ?

8 OCCUPATION

(a) Trade, profession, or  
particular kind of work.(b) General nature of industry,  
business, or establishment in  
which employed (or employer)

9 BIRTHPLACE

(State or country)

10 NAME OF  
FATHER11 BIRTHPLACE  
OF FATHER

(State or country)

12 MAIDEN NAME  
OF MOTHER13 BIRTHPLACE  
OF MOTHER

(State or country)

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

15

Filed

1/12, 1915 Henry Davis

REGISTRAR

✓ 81

"Bellevue"

STATE OF MARYLAND  
CERTIFICATE OF DEATHRegistration Dist. No. 302St. — Ward —

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

Jan 11, 1915  
(Month) (Day) (Year)17 I HEREBY CERTIFY, That I attended deceased from  
April 1, 1914, to Jan. 11, 1915,

that I last saw him alive on Jan. 11, 1915,

and that death occurred on the date stated above, at 5.30 P.M.

The CAUSE OF DEATH\* was as follows:

General exhaustion due  
to age

(Duration) yrs. mos. 3 ds.

Contributory Arterio-sclerosis  
Secondary

(Duration) years months days

(Signed) F. D. Hoffmann, M.D.  
Jan 12, 1915 (Address) Hagerstown, Md.

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence.

19 PLACE OF BURIAL OR REMOVAL

Catoctin Mts. Jan 13, 1915

20 UNDERTAKER

A. K. Coffman ADDRESS Hagerstown, Md.

# REVISED UNITED STATES STANDARD

## CERTIFICATE OF DEATH

[Approved by U. S. Census and American Public Health Association.]

**Statement of occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples:

(a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At Home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the disease causing death, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer* (*retired 6 yrs.*) For persons who have no occupation whatever, write *None*.

**Statement of cause of death**—Name, first, the disease causing death (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritonaeum*, etc., *Carcin-*

*oma*, *Sarcoma*, etc., of..... (name origin); "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Mensles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 *ds.*; *Bronchopneumonia* (secondary), 10 *ds.* Never report mere symptoms or terminal conditions, such as "Anæmia," "Anaæmia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsey," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marsmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "Puerperal septicæmia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent deaths state means of injury and quality as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Recover wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.

RECEIVED

FEB 6 1915

BUREAU, V. S.

## MARGIN RESERVED FOR BINDING

## WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH  
County Washington

V 1023  
79 STATE OF MARYLAND  
CERTIFICATE OF DEATH  
Registration Dist. No. 302

Village or City Hagerstown (No. 643, N. Mulberry St., 4<sup>th</sup> Ward)

2 FULL NAME Emma Lora Mack

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE white 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED MARRIED  
(Write the word)

6 DATE OF BIRTH June 11, 1852  
(Month) (Day) (Year)

7 AGE 62 yrs. 7 mos. 18 ds. If LESS than  
1 day, \_\_\_\_\_ hrs.  
OR \_\_\_\_\_ min. ?

8 OCCUPATION  
(a) Trade, profession, or particular kind of work. House wife  
(b) General nature of industry, business, or establishment in which employed (or employer)

9 BIRTHPLACE  
(State or country) Md.

10 NAME OF FATHER W. D. Smith

11 BIRTHPLACE OF FATHER  
(State or country) Md.

12 MAIDEN NAME OF MOTHER Sarah Schilling

13 BIRTHPLACE OF MOTHER  
(State or country) Md.

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE  
(Informant) Wm. Gold

(Address) Hagerstown Md

15 Filed 1/30, 1915 Henry Davis  
per J. E. Paul REGISTRAR

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH Jan. 29, 1915  
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from November 11, 1914, to Jan. 29, 1915,  
that I last saw her alive on Jan 29, 1915,

and that death occurred on the date stated above, at 8 P.M.

The CAUSE OF DEATH\* was as follows:  
Mitral Regurgitation  
(Chronic Endocarditis)

(Duration) 30 yrs. mos. ds.

Contributory Passive Congestion Mild  
Seconday and Aspiration (Duration) yrs. mos. ds.

(Signed) John M. Neely, M. D.  
Jan. 27, 1915 (Address) Hagerstown

\* State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place \_\_\_\_\_ yrs. mos. ds. In the State \_\_\_\_\_ yrs. mos. ds

Where was disease contracted, If not at place of death?

Former or usual residence \_\_\_\_\_

19 PLACE OF BURIAL OR REMOVAL Rose Hill DATE OF BURIAL 1/31, 1915

20 UNDERTAKER Watkins Minich ADDRESS Hagerstown Md.

If more blanks are needed, address State Registrar, 6 E. Franklin St., Balto., Requesting V. S. No. 1.

# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

[Approved by U. S. Census and American Public Health Association.]

**Statement of occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter*, *Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework, or At Home*, and children, not gainfully employed, as *At school or At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid, etc.* If the occupation has been changed or given up on account of the disease causing death, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.)* For persons who have no occupation whatever, write *None*.

**Statement of cause of death**—Name, first, the disease causing death (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritonacum, etc., Carcin-*

*oma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor", for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Examples: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Con genital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marrasmus," "Old Age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. For violent deaths state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.

RECEIVED

FEB 6 1915

BUREAU, V. S.

## WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH County <u>Washington</u>		
Village or City <u>Indian Spring</u> (No.)		
2 FULL NAME <u>Mable Virginia Hart</u>		
PERSONAL AND STATISTICAL PARTICULARS		
3 SEX <u>Female</u>	4 COLOR OR RACE <u>White</u>	5 SINGLE, MARRIED, WIDOWED, OR DIVORCED <u>Single</u> (Write the word)
6 DATE OF BIRTH <u>Nov 1, 1913</u> (Month) (Day) (Year)		
7 AGE <u>1 yrs 2 mos 12 ds</u>	If LESS than 1 day, .... hrs. OR min. ?	
8 OCCUPATION (a) Trade, profession, or particular kind of work. <u>Not given</u> (b) General nature of industry, business, or establishment in which employed (or employer) <u>500</u>		
9 BIRTHPLACE (State or country) <u>Washington Co</u>		
10 NAME OF FATHER <u>Not given</u>		
11 BIRTHPLACE OF FATHER (State or country) <u>Not given</u>		
12 MAIDEN NAME OF MOTHER <u>Bessie Hart</u>		
13 BIRTHPLACE OF MOTHER (State or country) <u>Washington Co</u>		
14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE (Informant) <u>Mrs Hart</u> (Address) <u>Big Pool</u>		
15 Filed <u>Jan 13, 1913</u>	W. B. Howell	REGISTRAR

If more blanks are needed, address State Registrar, 6 E. Franklin St., Balto., Requesting V. S. No. 1.

1024

STATE OF MARYLAND  
CERTIFICATE OF DEATH

Registration Dist. No. 314

St. \_\_\_\_\_ Ward)

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

(91)

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH Jan 12th, 1913  
(Month) (Day) (Year)17 I HEREBY CERTIFY, That I attended deceased from Jan 7th, 1913, to, 1913,that I last saw her alive on Jan 7th, 1913,and that death occurred on the date stated above, at 6 P.M.

The CAUSE OF DEATH\* was as follows:

Pneumonia

(Duration) yrs. mos. ds.

Contributory  
Secondary

(Duration) yrs. mos. ds.

(Signed) C. J. Mean, M. D.,  
Jan 13th, 1913 (Address) Clearspring, Md.

\* State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place \_\_\_\_\_ yrs. mos. ds. In the \_\_\_\_\_ State \_\_\_\_\_ yrs. mos. ds.

Where was disease contracted, if not at place of death? \_\_\_\_\_

Former or  
usual residence.19 PLACE OF BURIAL OR REMOVAL Mark Head DATE OF BURIAL Jan 13, 191320 UNDERTAKER Franz Bros & Co ADDRESS Clear Spring

# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

[Approved by U. S. Census and American Public Health Association.]

**Statement of occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter*, *Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary foreman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At Home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the disease causing death, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.)*. For persons who have no occupation whatever, write *None*.

**Statement of cause of death**—Name, first, the disease causing death (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritonaeum, etc.*, *Carcin-*

*oma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Examples: *Measles* (disease causing death), 29 d.s.; *Bronchopneumonia* (secondary), 10 d.s. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Con genital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. For violent deaths state means of INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *spasms, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.

RECEIVED

FEB 2 1915

BUREAU V.

## WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

## 1 PLACE OF DEATH

County Washington

Village or City Hagerstown (No. 338, South St)

2 FULL NAME Leatherwood Robbs

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE White 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED Married (Write the word)

## 6 DATE OF BIRTH

Sept 5, 1863  
(Month) (Day) (Year)

7 AGE 57 yrs. 4 mos. 16 ds. If LESS than 1 day, .... hrs. OR min. ?

## 8 OCCUPATION

(a) Trade, profession, or particular kind of work. House Work

(b) General nature of industry, business, or establishment in which employed (or employer) C

## 9 BIRTHPLACE

(State or country) New Jersey

## 10 NAME OF FATHER

John Meyers

## 11 BIRTHPLACE OF FATHER

(State or country) Germany

## 12 MAIDEN NAME OF MOTHER

No Record

## 13 BIRTHPLACE OF MOTHER

(State or country) Germany

## 14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Charles A. Robbs

(Address) Hagerstown, Md.

15 Filed 1-20, 1915 Henry Davis

REGISTRAR

## 1025 STATE OF MARYLAND CERTIFICATE OF DEATH

Registration Dist. No. 302

St. 3rd Ward)

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH Jan. 20, 1915, (Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from Jan. 15, 1915, to Jan. 20, 1915,

that I last saw her alive on Jan. 17, 1915,

and that death occurred on the date stated above, at 8:30 A.M.

The CAUSE OF DEATH\* was as follows:

Metral Rupture

of fever (Duration) yrs. mos. ds. acute delation

Contributory Secondary

J. Mead (Duration) yrs. mos. ds. M. D.

(Signed) J. Mead Jan 20, 1915 (Address) Hagerstown

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, If not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL Medford, N.J. DATE OF BURIAL Jan. 22, 1915

20 UNDERTAKER H. C. Gleason ADDRESS Hagerstown

# REVISED UNITED STATES STANDARD

## CERTIFICATE OF DEATH

[Approved by U. S. Census and American Public Health Association.]

**Statement of occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Cotton mill, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework, or At Home*, and children, not gainfully employed, as *At school or At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid, etc.* If the occupation has been changed or given up on account of the disease causing death, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.)* For persons who have no occupation whatever, write *None*.

**Statement of cause of death**—Name, first, the disease causing death (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritonaeum, etc., Carcin-*

oma, Sarcoma, etc., of..... (name origin); "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 d.; *Bronchopneumonia* (secondary), 10 d. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "Puerperal septicæmia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent deaths state means of injury and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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## WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

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1 PLACE OF DEATH  
County Washington

Village or City Cavetown (No. ....)

1026 STATE OF MARYLAND  
CERTIFICATE OF DEATH

Registration Dist. No. 306

(120)

St. .... Ward)

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME John P Hoffmann

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX male4 COLOR OR RACE white5 SINGLE,  
MARRIED,  
WIDOWED,  
OR DIVORCED  
(Write the word)single6 DATE OF BIRTH Unknown

(Month)

(Day)

(Year)

7 AGE 66

yrs.

mos.

ds.

If LESS than  
1 day, ..... hrs.  
OR ..... min. ?

## 8 OCCUPATION

(a) Trade, profession, or  
particular kind of workLabor(b) General nature of industry,  
business, or establishment in  
which employed (or employer)

## 9 BIRTHPLACE

(State or country)

Cavetown

## PARENTS

10 NAME OF  
FATHERPeter Hoffmann11 BIRTHPLACE  
OF FATHER  
(State or country)Germany12 MAIDEN NAME  
OF MOTHERAnnie Resmer13 BIRTHPLACE  
OF MOTHER  
(State or country)Cavetown

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Minnie Hoffmann

(Address)

Cavetown Md.

15

Filed

Jan 6, 1915J. H. Ferguson

REGISTRAR

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

January 6

(Month)

(Day)

(Year)

17 I HEREBY CERTIFY, That I attended deceased from

Aug 15, 1914 to Jan 6, 1915,that I last saw him alive on Jan 6, 1915,and that death occurred on the date stated above, at 10 A.M.

The CAUSE OF DEATH\* was as follows:

Cerebral interstitial  
meningitis(Duration) 1 yrs. 3 mos. 0 ds.

Contributory causes of death

Secondary

(Duration) 0 yrs. 0 mos. 4 ds.(Signed) G. A. St. John, M. D.Jan 6, 1915 (Address) Smithburg

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place 0 yrs. 0 mos. 0 ds. In the 0 yrs. 0 mos. 0 ds.Where was disease contracted, 0 yrs. 0 mos. 0 ds.

If not at place of death?

Former or 0 yrs. 0 mos. 0 ds.

usual residence.

19 PLACE OF BURIAL OR REMOVAL

Cavetown

20 UNDERTAKER

Wm H Downey

DATE OF BURIAL

Jan 8, 1915

ADDRESS

Smithburg

If more blanks are needed, address State Registrar, 6 E. Franklin St., Balto., Requesting V. S. No. 1.

# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

[Approved by U. S. Census and American Public Health Association.]

**Statement of occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner, Cotton mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer-Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework, or At home*, and children, not gainfully employed, as *At school or At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid, etc.* If the occupation has been changed or given up on account of the disease causing death, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.)* For persons who have no occupation whatever, write *None*.

**Statement of cause of death**—Name, first, the disease causing death (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Group"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritonaeum, etc., Cancer*

*oma, Sarcoma, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: Measles (disease causing death), 29 ds.; Bronchopneumonia (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Anæmia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Con genital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Masmus," "Old Age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "Puerperal septicemia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent deaths state means of injury and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide. The nature of the injury, as fracture of skull, and consequences (e. g., sepsis, tetanus) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)*

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RECEIVED

FEB 8 1915

BUREAU, U. S.

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WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

## 1 PLACE OF DEATH

County. *Washington*

1027

STATE OF MARYLAND  
CERTIFICATE OF DEATHRegistered No. *317*Village or City. *Maugansville* No. ,

St. Ward)

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME *Emma S. Horst*

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX *W*4 COLOR OR RACE *W*5 SINGLE,  
MARRIED,  
WIDOWED,  
OR DIVORCED  
(Write the word)

6 DATE OF BIRTH

may 30, 1913  
(Month) (Day) (Year)

7 AGE

1 7 8  
yrs. mos. ds.If LESS than  
1 day, hrs.  
OR min. ?

## 8 OCCUPATION

(a) Trade, profession, or  
particular kind of work(b) General nature of industry,  
business, or establishment in  
which employed (or employer)9 BIRTHPLACE  
(State or country)*Clearfors Md.*

## PARENTS

10 NAME OF  
FATHER*Jonas S. Horst*11 BIRTHPLACE  
OF FATHER  
(State or country)*Maugansville Md.*12 MAIDEN NAME  
OF MOTHER*Hannig S. Lasher*13 BIRTHPLACE  
OF MOTHER  
(State or country)*Franklin Co Pa*

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) *Jonas S. Horst.*(Address) *Maugansville Md.*

15

Filed *Jan. 9th, 1915* *S. A. Harnish*

REGISTRAR

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

*Jan 7, 1915*  
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from

*Dec 1, 1914* to *Jan 7, 1915*  
that I last saw *h. h. a.* alive on *Jan 7, 1915*and that death occurred on the date stated above, at *10 P. M.*

The CAUSE OF DEATH\* was as follows:

*Gastro Enteritis*Contributory  
(Secondary)

(Duration) yrs. mos. ds.

*Cardiac dysfunction*(Signed) *A. P. Haupfer* (Duration) yrs. mos. ds.*Jan 9, 1915* (Address) *M. D. Stogsdill M. D.*

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL

*Rivers cemetery* DATE OF BURIAL  
*Jan 10, 1915*

20 UNDERTAKER

*A. R. Brewbaker* ADDRESS  
*State Line Pa*

# REVISED UNITED STATES STANDARD

## CERTIFICATE OF DEATH

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*oma*, *Sarcoma*, etc., or ..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Examples: *Measles* (disease causing death), 29 *ds.*; *Bronchopneumonia* (secondary), 10 *ds.* Never report mere symptoms or terminal conditions, such as "Anesthesia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Malaria," "Old Age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "*puerperal septicemia*," "*puerperal peritonitis*," etc. State cause for which surgical operation was undertaken. For violent deaths state means of injury and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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## PARENTS

1 PLACE OF DEATH County <u>Washington</u>		1028 120
Village or City <u>Hagerstown</u> (No. 131, Ray)		Registration Dist. No. <u>302</u>
2 FULL NAME <u>Mary E. Hufman</u>		St. <u>3rd</u> Ward
PERSONAL AND STATISTICAL PARTICULARS		
3 SEX <u>Female</u>	4 COLOR OR RACE <u>white</u>	5 SINGLE, MARRIED, WIDOWED, OR DIVORCED <u>Widowed</u> (Write the word)
6 DATE OF BIRTH <u>May 1, 1880</u> (Month) (Day) (Year)		
7 AGE <u>64 yrs. 8 mos. 3 ds.</u>	If LESS than 1 day, hrs. OR min. ?	
8 OCCUPATION (a) Trade, profession, or particular kind of work. <u>House wife</u>		
(b) General nature of industry, business, or establishment in which employed (or employer)		
9 BIRTHPLACE (State or country) <u>Maryland</u>		
10 NAME OF FATHER <u>Noah Delmar</u>		
11 BIRTHPLACE OF FATHER (State or country) <u>Maryland</u>		
12 MAIDEN NAME OF MOTHER <u>Mary Hines</u>		
13 BIRTHPLACE OF MOTHER (State or country) <u>Maryland</u>		
14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE (Informant) <u>Raleigh V. Jett</u> (Address) <u>Hagerstown, Md.</u>		
15 Filed <u>1-5-5</u> Henry Davis		

STATE OF MARYLAND  
CERTIFICATE OF DEATH

16 DATE OF DEATH Jan 4, 1915  
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from Jan 1, 1915 to Jan 3, 1915,  
that I last saw her alive on Jan 3, 1915,  
and that death occurred on the date stated above, at 4:30 A.M.,  
The CAUSE OF DEATH\* was as follows  
Mitral Heart Disease  
Nephritis

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)  
At place of death years. months. days. In the State years. months. days.  
Where was disease contracted?  
If not at place of death?  
Former or usual residence.

19 PLACE OF BURIAL OR REMOVAL Hagerstown, Md. DATE OF BURIAL Jan 6, 1915

20 UNDERTAKER A. & C. Coffman ADDRESS Hagerstown, Md.

# REVISED UNITED STATES STANDARD

## CERTIFICATE OF DEATH

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FEB 6 1915

BUREAU, V. S.



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*oma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Examples: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Con genital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL septicæmia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. For violent deaths state means of injury and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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1 PLACE OF DEATH		1030
County	Washington	
Village or City	Millstone (No.)	
2 FULL NAME Roy E. Keefer		
PERSONAL AND STATISTICAL PARTICULARS		
3 SEX	4 COLOR OR RACE	5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word)
Mal	white	Single
6 DATE OF BIRTH		
Jan. 30		, 1914
(Month) (Day)		(Year)
7 AGE		
1 yrs.	9 mos.	18 ds.
If LESS than 1 day,..... hrs. OR..... min. ?		
8 OCCUPATION		
(a) Trade, profession, or particular kind of work.		
(b) General nature of industry, business, or establishment in which employed (or employer)		
9 BIRTHPLACE (State or country)		
10 NAME OF FATHER		
Ralph Keefer		
11 BIRTHPLACE OF FATHER (State or country)		
Md.		
12 MAIDEN NAME OF MOTHER		
Mary Mills		
13 BIRTHPLACE OF MOTHER (State or country)		
Md.		
14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE		
(Informant) Frank Shores		
(Address) Big Pool Ind.		
15 Filed Jan 14, 1915 by B. Hull		

REGISTRAR

STATE OF MARYLAND  
CERTIFICATE OF DEATH

Registration Dist. No. 314

St. Ward

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

Jan. 12, 1915

(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from

Jan. 11, 1915 to Jan. 12, 1915

that I last saw h..... alive on Jan. 11, 1915

and that death occurred on the date stated above, at..... m.

The CAUSE OF DEATH\* was as follows:

Cerebral Meningitis

(Duration) yrs. mos. 2 ds.

Contributory  
Secondary

(Duration) yrs. mos. ds.

(Signed) H. E. Tabber, M. D.

Jan. 13, 1915 (Address) Havre de Grace

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death yrs. mos. ds. In the State yrs. mos. ds

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL

Albert Zimmerman, Jan. 14, 1915

DATE OF BURIAL

20 UNDERTAKER

ADDRESS

Lankford Church and Lyman Par.

If more blanks are needed, address State Registrar, 6 E. Franklin St., Balto., Requesting V. S. No. 1.

# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

[Approved by U. S. Census and American Public Health Association.]

**Statement of occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer*, *Farm laborer*, *Laborer-Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At Home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the disease causing death, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer* (*retired 6 yrs.*) For persons who have no occupation whatever, write *None*.

## Statement of cause of death

Name, first, the disease causing death (the primary affection with respect to

time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritonaeum*, etc., *Carcin-*

*oma*, *Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Examples: *Measles* (disease causing death), *29 ds.*; *Bronchopneumonia* (secondary), *10 ds.* Never report more symptoms or terminal conditions, such as "Anæmia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. For violent deaths state means of INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *teramus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.



## WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH  
County.....

Village or City..... (No.).....

2 FULL NAME *Gela Vilo Kindle*

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX *Female* 4 COLOR OR RACE *White* 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED *Married*  
(Write the word)

6 DATE OF BIRTH

*11 13, 1862*  
(Month) (Day) (Year)

7 AGE

*52 1 29*  
yrs. mos. ds. If LESS than  
1 day, hrs.  
OR min. ?

8 OCCUPATION

(a) Trade, profession, or  
particular kind of work.  
(b) General nature of industry,  
business, or establishment in  
which employed (or employer)

9 BIRTHPLACE  
(State or country)

10 NAME OF  
FATHER

11 BIRTHPLACE  
OF FATHER  
(State or country)

12 MAIDEN NAME  
OF MOTHER

13 BIRTHPLACE  
OF MOTHER  
(State or country)

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) *Frank Kindle*

(Address) *Frankstown*

15

Filed..... 191.....

REGISTRAR

1031

92

STATE OF MARYLAND  
CERTIFICATE OF DEATH

Registration Dist. No. *309*

St. Ward)

[If death occurred in  
a hospital or institution,  
give its NAME instead  
of street and number.]

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH *Jun 30, 1915*  
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from *Jun 24, 1915*, to *Jun 30, 1915*,  
that I last saw *her* alive on *Jun 28, 1915*,  
and that death occurred on the date stated above, at *5 a.m.*  
The CAUSE OF DEATH\* was as follows:

*Acute Lobar Pneumonia*

(Duration) yrs. mos. 6 ds.

Contributory  
Secondary

(Duration) yrs. mos. ds.

(Signed) *Thos. S. Humphrey, M. D.*  
*Jun 31, 1915* (Address) *Blawoodville Md.*

\* State the DISEASE causing death, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL

*Frankstown* DATE OF BURIAL *Feb 1915*

20 UNDERTAKER

*L F Keecher* ADDRESS *Frankstown*

# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

[Approved by U. S. Census and American Public Health Association.]

**Statement of occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age.

For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*; *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary foreman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples:

(a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer*, *Farm laborer*, *Laborer*—*Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At Home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the disease causing death, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer* (*retired 6 yrs.*) For persons who have no occupation whatever, write *None*.

**Statement of cause of death**—Name, first, the disease causing death (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritonaeum*, etc., *Carcin-*

*oma*, *Sarcoma*, etc., of..... (name origin); "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Examples: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Anæmia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Con genital," "Senile," etc.), "Dropsey," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marmasmus," "Old Age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "Puerperal septicæmia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent deaths state means of injury and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railroad train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.

RECEIVED

MAR 3 1915

BUREAU, U. S.

## WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH  
County. WASHINGTON

Village or City HAGERSTOWN (No. 347, WEST ANTIETAM St. 2<sup>nd</sup> Ward)

1032

64

STATE OF MARYLAND  
CERTIFICATE OF DEATH

Registration Dist. No. 302

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME MRS. ALICE V. KNODE

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX FEMALE	4 COLOR OR RACE WHITE	5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write WIDOW.)
-----------------	--------------------------	--

6 DATE OF BIRTH

OCTOBER 8<sup>th</sup>, 1850.  
(Month) (Day) (Year)

7 AGE 64 yrs. 3 mos. 13 ds.	If LESS than 1 day, hrs. OR min. ?
--------------------------------	--

8 OCCUPATION  
(a) Trade, profession, or  
particular kind of work.  
HOUSEWORK  
(b) General nature of industry,  
business, or establishment in  
which employed (or employer)  
" " " " " " " "

9 BIRTHPLACE  
(State or country)  
MARYLAND.

10 NAME OF  
FATHER  
HENRY KINDLE.

11 BIRTHPLACE  
OF FATHER  
(State or country)  
MARYLAND.

12 MAIDEN NAME  
OF MOTHER  
NOT KNOWN

13 BIRTHPLACE  
OF MOTHER  
(State or country)  
" " " " " "

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) DAVID KNODE

(Address) # 647 FOREST DRIVE

15 Filed 1/22, 1916 *Henry Davis*

REGISTRAR

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

1 21, 1915  
(Month) (Day) (Year)17 I HEREBY CERTIFY, That I attended deceased from  
Och 11, 1915, to Jan 21, 1915,that I last saw him alive on Jan 21, 1915,  
and that death occurred on the date stated above, at 2:20 P.M.

The CAUSE OF DEATH\* was as follows:

*Organic heart disease  
of heart & vessels*

Contributory  
Secondary  
Duration yrs. 6 mos. 3 ds.

(Signed) *Henry Davis* (Address) 1/27, 1916, M. D.

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted,  
If not at place of death?Former or  
usual residence.

19 PLACE OF BURIAL OR REMOVAL

ROSE HILL CEMETERY DATE OF BURIAL JAN. 23, 1916

20 UNDERTAKER C. M. SUTER &amp; SON ADDRESS HAGERSTOWN MD

# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

[Approved by U. S. Census and American Public Health Association.]

**Statement of occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples:

(a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At Home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the disease causing death, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer* (*retired 6 yrs.*) For persons who have no occupation whatever, write *None*.

**Statement of cause of death**—Name, first, the disease causing death (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Group"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum, etc., Cancer*.

*oma*, *Sarcoma*, etc., of..... (name origin); "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 d.s.*; *Bronchopneumonia* (secondary), *10 d.s.* Never report mere symptoms or terminal conditions, such as "Anemia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Con genital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL septic infection," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. For violent death state means of INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *scaphis, tectorum*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.

RECEIVED
FEB 6 1915
BUREAU, V. S.

## WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

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## 1 PLACE OF DEATH

County Washington

1033

STATE OF MARYLAND  
CERTIFICATE OF DEATHRegistration Dist. No. 302St. 9th Ward

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

Village or City Hagerstown (No. 220) Washington

2 FULL NAME Saville J. Koontz

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX female 4 COLOR OR RACE white 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED married  
(Write the word)

6 DATE OF BIRTH Nov. 26 (Month) 1838 (Year)

7 AGE 76 yrs. 1 mos. 12 ds. If LESS than 1 day, .... hrs. OR min. ?

8 OCCUPATION housewife  
(a) Trade, profession, or particular kind of work.  
(b) General nature of industry, business, or establishment in which employed (or employer)

9 BIRTHPLACE Maryland  
(State or country)

10 NAME OF FATHER Jacob Stonner

11 BIRTHPLACE OF FATHER Maryland  
(State or country)

12 MAIDEN NAME OF MOTHER Katherine Stonifer

13 BIRTHPLACE OF MOTHER Maryland  
(State or country)

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) John Koontz  
(Address) Hagerstown, Md.

15 Filed 1-9-1915 Henry Davis

REGISTRAR

(120)

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH Jan 8, 1915

(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from Dec 24, 1914 to Jan 8, 1915,

that I last saw her alive on Jan 7, 1915, and that death occurred on the date stated above, at 10:30 p.m.  
The CAUSE OF DEATH\* was as follows:

Nephritis and organ failure

(Duration) yrs. 6 mos. 0 ds. Contributory Acute Gastritis & Enteritis

Secondary in (Duration) yrs. 4 mos. 0 ds.

(Signed) W. E. Coffman, M. D. 1/9, 1915 (Address) Hagerstown, Md.

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence.

19 PLACE OF BURIAL OR REMOVAL Westminster, Md. DATE OF BURIAL Jan 10, 1915

20 UNDERTAKER A. H. Coffman ADDRESS Hagerstown, Md.

# REVISED UNITED STATES STANDARD

## CERTIFICATE OF DEATH

[Approved by U. S. Census and American Public Health Association.]

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(a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc. without more precise specification as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At Home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the disease causing death, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.)* For persons who have no occupation whatever, write *None*.

**Statement of cause of death**—Name, first, the disease causing death (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritonaeum, etc., Cancer*

*oma, Sarcoma, etc., of..... (name origin); "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Menses*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Examples: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Con genital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marsmus," "Old Age," "Shock," "Urtremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL septicæmia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. For violent deaths state MEANS OF INJURY and quality as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)*

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.

FEB 6 1915  
BUREAU, V. S.

## WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH  
County WASHINGTON

Village or City HAGERSTOWN (No.) WEST CHURCH

1634

STATE OF MARYLAND  
CERTIFICATE OF DEATH

Registration Dist. No. 302

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME CLIFTON LEGGETT

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the name of the spouse)
MALE	WHITE	MARRIED

## 6 DATE OF BIRTH

JANUARY 25<sup>th</sup>, 1886.  
(Month) (Day) (Year)

## 7 AGE

28 yrs. 11 mos. 15 ds. If LESS than  
1 day, hrs.  
OR min. ?

## 8 OCCUPATION

(a) Trade, profession, or  
particular kind of work.  
LABORER  
(b) General nature of industry,  
business, or establishment in  
which employed (or employer)  
\*\*\*\*\*

9 BIRTHPLACE  
(State or country)

MARYLAND.

10 NAME OF  
FATHER

ZACHARIAH T. LEGGETT

11 BIRTHPLACE  
OF FATHER  
(State or country)

MARYLAND.

12 MAIDEN NAME  
OF MOTHER

MARTHA C. LYNCH

13 BIRTHPLACE  
OF MOTHER  
(State or country)

MARYLAND.

## 14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) CLARENCE LEGGETT

(Address) MARTINSBURG, W. VA.

## 15

Filed 1-12-1915 Henry Davis

REGISTRAR

## MEDICAL CERTIFICATE OF DEATH

## 16 DATE OF DEATH

January 10, 1915  
(Month) (Day) (Year)

## 17 I HEREBY CERTIFY, That I attended deceased from

191... 191...  
that I last saw him alive on January 10, 1915.  
and that death occurred on the date stated above, at 2 P.M.  
The CAUSE OF DEATH\* was as follows:

Gun shot wound of  
head. Wounded

(Duration) yrs. mos. ds.

Contributory  
Secondary

7 M. D. (Duration) yrs. mos. ds.

(Signed) M. D. Jan 11, 1915 (Address) Hagerstown Md.

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

## 18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted,  
if not at place of death?

Former or  
usual residence

## 19 PLACE OF BURIAL OR REMOVAL

BOONSBORO CEMETERY

## DATE OF BURIAL

JAN 12<sup>th</sup>, 1915

## 20 UNDERTAKER

C. M. SUTER &amp; SON

## ADDRESS

HAGERSTOWN MD.

# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

[Approved by U. S. Census and American Public Health Association.]

**Statement of occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples:

(a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At Home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the disease causing death, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.)* For persons who have no occupation whatever, write *None*.

**Statement of cause of death**—Name, first, the disease causing death (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Group"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritonaeum*, etc., *Carcin-*

*oma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 d.*; *Bronchopneumonia* (secondary), *10 d.* Never report mere symptoms or terminal conditions, such as "Anemia," "Anæmia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "Puerperal septicæmia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent deaths state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.

RECEIVED

FEB 6 1915

BUREAU, U. S.

## WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

## 1 PLACE OF DEATH

County Washington

Village or City Williamsport (No.)

1035

STATE OF MARYLAND  
CERTIFICATE OF DEATHRegistration Dist. No. 301

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

## 2 FULL NAME

Charles B Long.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Male

4 COLOR OR RACE

White5 SINGLE,  
MARRIED,  
WIDOWED,  
OR DIVORCED  
(Write the word)Single

6 DATE OF BIRTH

Nov 2, 1899  
(Month) (Day) (Year)

7 AGE

17 yrs. 2 mos. 22 ds.  
If LESS than  
1 day, ..... hrs.  
OR ..... min. ?

## 8 OCCUPATION

(a) Trade, profession, or  
particular kind of work.(b) General nature of industry,  
business, or establishment in  
which employed (or employer)

Presser  
Barnhart  
overall company

## 9 BIRTHPLACE

(State or country)

Maryland

## PARENTS

10 NAME OF  
FATHERJohnathon S. Long.11 BIRTHPLACE  
OF FATHER  
(State or country)Maryland12 MAIDEN NAME  
OF MOTHERAmanda T. Collins13 BIRTHPLACE  
OF MOTHER  
(State or country)Maryland

## 14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Amanda T. Long

(Address)

Williamsport Md

15

Filed Jan. 26, 1915 C. E. Beckard  
Local

REGISTRAR

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

January 24, 1915  
(Month) (Day) (Year)

17 I HEREBY CERTIFY, that I attended deceased from  
Jan 19, 1915 to Jan. 24, 1915

that I last saw him alive on Jan. 24, 1915

and that death occurred on the date stated above, at 3 P.M.

The CAUSE OF DEATH\* was as follows:

Typhoid Fever

(Duration) yrs. mos. ds. Bronchopneumonia

Contributory Secondary (Duration) yrs. mos. ds.

(Signed) C. E. Richardson, M. D.  
Jan. 25, 1915 (Address) Williamsport Md

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place yrs. mos. ds. In the  
of death yrs. mos. ds. State yrs. mos. ds

Where was disease contracted,  
If not at place of death?

Former or  
usual residence

## 19 PLACE OF BURIAL OR REMOVAL

Williamsport Md

DATE OF BURIAL

Jan. 27, 1915

## 20 UNDERTAKER

L. W. Kieps

ADDRESS

Williamsport Md

# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

[Approved by U. S. Census and American Public Health Association.]

**Statement of occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At Home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the disease causing death, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.)* For persons who have no occupation whatever, write *None*.

**Statement of cause of death**—Name, first, the disease causing death (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Group"); <sup>3</sup>*Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritonaeum, etc., Carcin-*

*oma, Sarcoma, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: Measles (disease causing death), 29 ds.; Bronchopneumonia (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Anæmia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marsmus," "Old Age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL septicæmia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. For violent deaths state means of INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)*

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.

RECEIVED
FEB 6 1915
BUREAU. V.S.



# REVISED UNITED STATES STANDARD

## CERTIFICATE OF DEATH

[Approved by U. S. Census and American Public Health Association.]

**Statement of occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Composer*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer*, *Farm laborer*, *Laborer—Cotton mill*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At Home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the disease causing death, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer* (*retired 6 yrs.*) For persons who have no occupation whatever, write *None*.

**Statement of cause of death**—Name, first, the disease causing death (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritonaeum*, etc., *Carcin-*

oma, *Sarcoma*, etc., or..... (name origin); "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Examples: *Measles* (disease causing death), 29 *ds.*; *Bronchopneumonia* (secondary), 10 *ds.* Never report mere symptoms or terminal conditions, such as "Anæmia," "Anæmia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL septicæmia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. For violent deaths state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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**RECEIVED**  
FEB 6 1915  
BUREAU, V. S.

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N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See Instructions on back of certificate.

1 PLACE OF DEATH  
County Washington

Village or City Hayesboro (No.)

1087

STATE OF MARYLAND  
CERTIFICATE OF DEATHRegistration Dist. No. 302

Age 55  
5<sup>th</sup> Ward

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME John W. M. Wade

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE White 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED Marius  
(Write the word)

6 DATE OF BIRTH Sept 27 (Month) 1847 (Year)

7 AGE 66 yrs. 3 mos. 15 ds. If LESS than 1 day,.....hrs. OR min. ?

8 OCCUPATION  
(a) Trade, profession, or particular kind of work. Carpenter  
(b) General nature of industry, business, or establishment in which employed (or employer)

9 BIRTHPLACE Maryland  
(State or country)

10 NAME OF FATHER Samuel M. Wade

11 BIRTHPLACE OF FATHER Maryland  
(State or country)

12 MAIDEN NAME OF MOTHER Jane Hawthorne

13 BIRTHPLACE OF MOTHER Maryland  
(State or country)

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Mrs. John W. M. Wade

(Address) Salem, An. Hayesboro

15 Filed 1/13, 1915, Henry Davis

REGISTRAR

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH Jan 12, 1915

(Month) Jan (Day) 12 (Year) 1915

17 I HEREBY CERTIFY, That I attended deceased from Jan 11, 1915, to Jan 12, 1915,

that I last saw him alive on Jan 12, 1915

and that death occurred on the date stated above, at 1 P.M.

The CAUSE OF DEATH\* was as follows:

Carcinoma of rectum?

I only saw him once in his last hours and can make no other diagnosis.

(Duration) 5 yrs. 5 mos. 0 ds.

(Signed) Wm. P. Wilson, M. D.

Jan 12, 1915 (Address) Hospital and

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place \_\_\_\_\_ In the \_\_\_\_\_  
of death \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds. State \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds

Where was disease contracted, \_\_\_\_\_  
If not at place of death? \_\_\_\_\_

Former or usual residence \_\_\_\_\_

19 PLACE OF BURIAL OR REMOVAL Middleburg, Md. DATE OF BURIAL Jan 14, 1915

20 UNDERTAKER R. & C. Coffman ADDRESS Hayesboro

# REVISED UNITED STATES STANDARD

## CERTIFICATE OF DEATH

[Approved by U. S. Census and American Public Health Association.]

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**Statement of cause of death**—Name, first, the disease causing death (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritonaeum*, etc., *Carcin-*

*oma, Sarcoma*, etc., or..... (name origin); "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic tubular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Examples: *Measles* (disease causing death), 29 *ds.*; *Bronchopneumonia* (secondary), 10 *ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Mastitis," "Old Age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "Puerperal septicæmia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent deaths state means of injury and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *scpsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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RECEIVED

FEB 6 1915

BUREAU, V.S.

## WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

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## 1 PLACE OF DEATH

County Washington S 1038

Village or City Smithsburg (No.)

2 FULL NAME Sarah Bethy

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX <u>Male</u>	4 COLOR OR RACE <u>White</u>	5 SINGLE, MARRIED, WIDOWED, OR DIVORCED <u>—</u> (Write the word)
-------------------	------------------------------	--

## 6 DATE OF BIRTH

Sept Birth, 1915  
(Month) (Day) (Year)

7 AGE <u>—</u> yrs. <u>—</u> mos. <u>—</u> ds.	IF LESS than 1 day, <u>—</u> hrs. <u>—</u> min. ?
--	---

## 8 OCCUPATION

(a) Trade, profession, or particular kind of work —

(b) General nature of industry, business, or establishment in which employed (or employer) —

9 BIRTHPLACE  
(State or country)

Smithsburg

## PARENTS

## 10 NAME OF FATHER

Walter H. McPherson

11 BIRTHPLACE OF FATHER  
(State or country)

Smithsburg

## 12 MAIDEN NAME OF MOTHER

Susan Carroll

13 BIRTHPLACE OF MOTHER  
(State or country)

Waynesboro Pa.

## 14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) W. H. McPherson

(Address) Smithsburg Pa.

## 15

Filed Jan. 23, 1915 — J. H. Ferguson  
REGISTRAR

STATE OF MARYLAND  
CERTIFICATE OF DEATH

Registration Dist. No. 306

St; — Ward McPherson

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

## MEDICAL CERTIFICATE OF DEATH

## 16 DATE OF DEATH

Jan 22, 1915  
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from Jan 22, 1915, to Jan 22, 1915, that I last saw her alive on Jan 22, 1915,

and that death occurred on the date stated above, at 7:00 a.m. The CAUSE OF DEATH\* was as follows:

accident

(Duration) yrs. mos. ds.

Contributory  
(Secondary)

(Duration) yrs. mos. ds.

(Signed) G. A. Johnson, M. D.  
Jan 22, 1915 (Address) Smithsburg

\* State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

## 18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

## 19 PLACE OF BURIAL OR REMOVAL

Smithsburg DATE OF BURIAL Jan 25, 1915

## 20 UNDERTAKER

William H. Downey Smithsburg ADDRESS

# REVISED UNITED STATES STANDARD

## CERTIFICATE OF DEATH

[Approved by U. S. Census and American Public Health

Association.]

Statement of occupation—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary foreman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the disease causing death, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of cause of death—Name, first, the disease causing death (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Oerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Group"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritonaeum*, etc.; *Carcin-*

*oma*, *Sarcoma*, etc., or ..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 *ds.*; *Bronchopneumonia* (secondary), 10 *ds.* Never report mere symptoms or terminal conditions, such as "Asthma," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL septicæmia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. For violent deaths state MEANS OF INJURY and quality as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.

RECEIVED
FEB 8 1915
BUREAU, V.S.

## WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1039

STATE OF MARYLAND  
CERTIFICATE OF DEATH

Registration Dist. No. 308

St. Ward

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

**1 PLACE OF DEATH**  
County *Washington* (No. *64*)  
Village or City *Leitersburg* (No. *64*)

**2 FULL NAME** *Emanuel Martin*

**PERSONAL AND STATISTICAL PARTICULARS**

<b>3 SEX</b> <i>Male</i>	<b>4 COLOR OR RACE</b> <i>White</i>	<b>5 SINGLE, MARRIED, WIDOWED, OR DIVORCED</b> (Write the word) <i>Single</i>
<b>6 DATE OF BIRTH</b> <i>4 25</i>		(Month) (Day) (Year) <i>1854</i>
<b>7 AGE</b> <i>70 yrs. 8 mos. 7 ds.</i>		If LESS than 1 day, hrs. OR min. ?

**8 OCCUPATION**  
(a) Trade, profession, or particular kind of work.  
*Stone Mason*  
(b) General nature of industry, business, or establishment in which employed (or employer)  
*214*

**9 BIRTHPLACE**  
(State or country)  
*Fred Lee Md*

**10 NAME OF FATHER**  
*Emanuel Martin*

**11 BIRTHPLACE OF FATHER**  
(State or country)  
*Fred Lee Md*

**12 MAIDEN NAME OF MOTHER**  
*Asmee Doyle*

**13 BIRTHPLACE OF MOTHER**  
(State or country)  
*Don't Know*

**14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE**  
(Informant)  
*Miss Kate Martin*  
(Address)  
*Leitersburg Md*

**15**  
Filed *Jan. 2, 1915* by *J. H. Wishard*  
REGISTRAR

**16 DATE OF DEATH**  
*Jan. 2, 1915*  
(Month) (Day) (Year)

**17 I HEREBY CERTIFY, That I attended deceased from**  
*Nov. 22, 1914* to *Jan. 2, 1915*,  
that I last saw *him* alive on *Jan. 2, 1915*,  
and that death occurred on the date stated above, at *12* m.  
The CAUSE OF DEATH\* was as follows:  
*General Hemorrhage*

**18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)**  
At place  
of death yrs. mos. ds. in the State yrs. mos. ds.  
Where was disease contracted,  
If not at place of death?  
Former or  
usual residence

**19 PLACE OF BURIAL OR REMOVAL**  
*Leitersburg Md* DATE OF BURIAL  
*Jan. 4, 1915*

**20 UNDERTAKER**  
*Geo. B. Hoover Smithsburg* ADDRESS

If more blanks are needed, address State Registrar, 6 E. Franklin St., Balto., Requesting V. S. No. 1.

# REVISED UNITED STATES STANDARD

## CERTIFICATE OF DEATH

[Approved by U. S. Census and American Public Health Association.]

**Statement of occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry; and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples:

(a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At Home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the disease causing death, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.)*. For persons who have no occupation whatever, write *None*.

**Statement of cause of death**—Name, first, the disease causing death (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritonaeum*, etc.; *Carcin-*

oma

oma. *Sureooma*, etc., of \_\_\_\_\_ (name origin); "Can-  
cer" is less definite; avoid use of "Tumor" for malig-  
nant neoplasms); *Measles*; *Whooping cough*; *Chronic  
valvular heart disease*; *Chronic interstitial nephritis*,  
etc. The contributory (secondary or intercurrent)  
affection need not be stated unless important. Ex-  
ample: *Measles* (disease causing death), *29 ds.*  
*Bronchopneumonia* (secondary), *10 ds.* Never report  
mere symptoms or terminal conditions, such as "As-  
thenia," "Anaemia" (merely symptomatic), "Atrophy,"  
"Collapse," "Coma," "Convulsions," "Debility" ("Con-  
genital," "Senile," etc.), "Dropsy," "Exhaustion,"  
"Heart failure," "Haemorrhage," "Inanition," "Maras-  
mus," "Old Age," "Shock," "Uraemia," "Weakness,"  
etc., when a definite disease can be ascertained as the  
cause. Always qualify all diseases resulting from  
childbirth or miscarriage, as "PUERPERAL septicem-  
ia," "PUERPERAL peritonitis," etc. State cause for  
which surgical operation was undertaken. For VO-  
LENT DEATHS state MEANS OF INJURY and qualify as  
ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably*  
such, if impossible to determine definitely. Examples:  
*Accidental drowning*; *Struck by railway train—accident*;  
*Revolver wound of head—homicide*; *Poisoned  
by carbolic acid—probably suicide*. The nature of the  
injury, as fracture of skull, and consequences (e. g.,  
*sepsis*, *tetanus*) may be stated under the head of  
"Contributory." (Recommendations on statement of  
cause of death approved by Committee on Nomencla-  
ture of the American Medical Association.)

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# REVISED UNITED STATES STANDARD

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*oma*, *Sarcoma*, etc., of..... (name origin); "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 d.; *Bronchopneumonia* (secondary), 10 d. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsey," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "Puerperal septicemia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent deaths state means of injury and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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## 1 PLACE OF DEATH

County Washing Co

1041

STATE OF MARYLAND  
CERTIFICATE OF DEATHRegistration Dist. No. 314

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

92

Village or City Millstone (No.)

St. \_\_\_\_\_ Ward \_\_\_\_\_

## 2 FULL NAME

Preston Miller

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Male

4 COLOR OR RACE

white

5 SINGLE,  
MARRIED,  
WIDOWED,  
OR DIVORCED  
(Write the word)

Married

6 DATE OF BIRTH

Feb 24, Unknown  
(Month) (Day) (Year)

7 AGE

44 yrs. 10 mos. 10 ds.

If LESS than  
1 day, hrs.  
OR min. ?

## 8 OCCUPATION

(a) Trade, profession, or  
particular kind of work(b) General nature of industry,  
business, or establishment in  
which employed (or employer)Labor

## 9 BIRTHPLACE

(State or country)

Wash Co, Md

## PARENTS

## 10 NAME OF FATHER

Jacob Miller

## 11 BIRTHPLACE OF FATHER

(State or country)

Wash Co, Md

## 12 MAIDEN NAME OF MOTHER

Molinda Myers

## 13 BIRTHPLACE OF MOTHER

(State or country)

Unknown

## 14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(informant)

(Address)

Jacob MillerMillstone

15

Filed Jan. 14, 1915 by DR B. B. Hull

REGISTRAR

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

Jan 13, 1915  
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from

Dec 24, 1914, to Jan 13, 1915

that I last saw him alive on Jan 12, 1915

and that death occurred on the date stated above, at 2:30 a.m.

The CAUSE OF DEATH\* was as follows:

Lobar Pneumonia

(Duration) yrs. mos. ds.

Contributory Pneumonia and  
Secondary

Pericarditis (Duration) yrs. mos. ds.

(Signed) A. E. Taber, M. D., 191 (Address) Hancock, Md

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted,  
If not at place of death?Former or  
usual residence.19 PLACE OF BURIAL OR REMOVAL Bethel Church Jan 13, 1915

DATE OF BURIAL

20 UNDERTAKER

ADDRESS Albert Zimmerman Sylvan Pa

# REVISED UNITED STATES STANDARD

## CERTIFICATE OF DEATH

[Approved by U. S. Census and American Public Health Association.]

Association.]

**Statement of occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework, or At Home*, and children, not gainfully employed, as *At school or At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the disease causing death, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.)* For persons who have no occupation whatever, write *None*.

**Statement of cause of death**—Name, first, the disease causing death (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritonaeum, etc., Cancer*,

*oma, Sarcoma, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Examples: Measles (disease causing death), 29 ds.; Bronchopneumonia (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Con genital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Masmus," "Old Age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL septicemia," "PURPERAL peritonitis," etc. State cause for which surgical operation was undertaken. For violent deaths state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)*

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RECORDED

FEB 2 1915

BUREAU, U. S.

## WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH  
County Washington

Village or City Hagerstown (No. 327, H Mulhern)

1042 STATE OF MARYLAND  
CERTIFICATE OF DEATH

Registration Dist. No. \_\_\_\_\_

189

St. 4 Ward)

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME Rebecca Miller

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE white 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED Widow  
(Write the word)

## 6 DATE OF BIRTH

July 4, 1840  
(Month) (Day) (Year)

## 7 AGE

74 yrs. 5 mos. 17 ds.

If LESS than  
1 day, .... hrs.  
OR ..... min. ?

## 8 OCCUPATION

(a) Trade, profession, or particular kind of work  
Housewife  
(b) General nature of industry, business, or establishment in which employed (or employer)

## 9 BIRTHPLACE

(State or country)

Pa.

## PARENTS

## 10 NAME OF FATHER

Isaac Yonderwick

## 11 BIRTHPLACE OF FATHER

(State or country)

Pa

## 12 MAIDEN NAME OF MOTHER

Elizabeth Fult

## 13 BIRTHPLACE OF MOTHER

(State or country)

Pa.

## 14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Mrs. J D Sanders

(Address) Hagerstown Md.

## 15

Filed 1/18- 1915 Harry Davis

REGISTRAR

If more blanks are needed, address State Registrar, 6 E. Franklin St., Balto., Requesting V. S. No. 1.

## MEDICAL CERTIFICATE OF DEATH

## 16 DATE OF DEATH

Jan. 17-, 1915  
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from

, 191..., to , 191...,

that I last saw h. alive on , 191...

and that death occurred on the date stated above, at 6.30 P.m.

The CAUSE OF DEATH\* was as follows:

Unknown  
Nurse attended patient -- Was called & found her dead upon arrival

Contributory  
Secondary

(Duration) yrs. mos. ds.

(Signed) H. See Davis M. D.  
Jan. 18, 1915 (Address) Hagerstown Md.

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

## 18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death yrs. mos. ds. In the State yrs. mos. ds

Where was disease contracted, if not at place of death?

Former or usual residence.

## 19 PLACE OF BURIAL OR REMOVAL

Shanandoah Pa DATE OF BURIAL Jan 19, 1915

## 20 UNDERTAKER

Matthew & Minch ADDRESS Hag Md.

# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

[Approved by U. S. Census and American Public Health Association.]

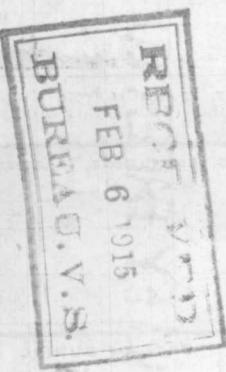
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## WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See Instructions on back of certificate.

## 1 PLACE OF DEATH

County Washington

Village or City Hagerstown (No. 710)

1043 STATE OF MARYLAND  
CERTIFICATE OF DEATH

Registration Dist. No. 302

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

## 2 FULL NAME

Suff. Moore

## PERSONAL AND STATISTICAL PARTICULARS

## 3 SEX

Male

## 4 COLOR OR RACE

white

5 SINGLE,  
MARRIED,  
WIDOWED,  
OR DIVORCED  
(Write the word)

single

## 6 DATE OF BIRTH

Jan. 26, 1915  
(Month) (Day) (Year)

## 7 AGE

— yrs. — mos. — ds.

If LESS than  
1 day, .... hrs.  
OR .... min. ?

## 8 OCCUPATION

(a) Trade, profession, or  
particular kind of work

(b) General nature of industry,  
business, or establishment in  
which employed (or employer)

## 9 BIRTHPLACE

(State or country)

Md

## PARENTS

## 10 NAME OF FATHER

b. W. Moore

## 11 BIRTHPLACE OF FATHER

(State or country)

Md

## 12 MAIDEN NAME OF MOTHER

Lizzie Witman

## 13 BIRTHPLACE OF MOTHER

(State or country)

Pa

## 14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) b. W. Moore

(Address) Hagerstown, Md.

## 15

Filed 1/27, 1915

By Henry Davis

REGISTRAR

## MEDICAL CERTIFICATE OF DEATH

## 16 DATE OF DEATH

Jan 26, 1915  
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from

that I last saw him alive on Jan 26, 1915

and that death occurred on the date stated above, at 5:30 m.

The CAUSE OF DEATH\* was as follows:

Difficult labor

2 hrs (Duration) Yrs. mos. ds.

Contributory  
Secondary

(Still Born)

(Signed) Mary A. Laughlin, M. D.  
(Address) Jan 26, 1915 Hagerstown

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

## 18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death Yrs. mos. ds. In the State Yrs. mos. ds.

Where was disease contracted,  
If not at place of death?

Former or  
usual residence

## 19 PLACE OF BURIAL OR REMOVAL

Hagerstown, Md. DATE OF BURIAL 1/27, 1915

## 20 UNDERTAKER

Father ADDRESS  
b. W. Moore Hagerstown

# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

[Approved by U. S. Census and American Public Health Association.]

**Statement of occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter*, *Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer*, *Farm laborer*, *Laborer—Coal mining*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework, or At Home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the disease causing death, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.)* For persons who have no occupation whatever, write *None*.

**Statement of cause of death**—Name, first, the disease causing death (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritonaeum*, etc., *Carcinoma*, *Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor", for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Examples: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Anæmia," "Anaæmia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Contingent," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marrasmus," "Old Age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "*Puerperal septicæmia*," "*Puerperal peritonitis*," etc. State cause for which surgical operation was undertaken. For violent deaths state means of injury and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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RECEIVED

FEB 6 1915

BUREAU, U. S.

## MARGIN RESERVED FOR BINDING

## WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

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1 PLACE OF DEATH		
County <u>Washington</u> <span style="border: 1px solid black; border-radius: 50%; padding: 5px; display: inline-block;">120</span> 1044		
Village or City <u>New Hagerstown</u> <span style="border: 1px solid black; border-radius: 50%; padding: 5px; display: inline-block;">79</span>		
2 FULL NAME <u>Mary Nally</u>		
PERSONAL AND STATISTICAL PARTICULARS		
3 SEX	4 COLOR OR RACE	5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word)
Female	White	Married
6 DATE OF BIRTH		
Aug		11, 1893
(Month)		(Day)
		(Year)
7 AGE	If LESS than 1 day, .... hrs. OR min. ?	
81 yrs. 5 mos. 15 ds.		
8 OCCUPATION (a) Trade, profession, or particular kind of work <u>House wife</u>		
(b) General nature of industry, business, or establishment in which employed (or employer)		
9 BIRTHPLACE (State or country) <u>Maryland</u>		
10 NAME OF FATHER <u>Jacob Bussard</u>		
11 BIRTHPLACE OF FATHER (State or country) <u>Frederick</u>		
12 MAIDEN NAME OF MOTHER <u>Margaret Keeplinger</u>		
13 BIRTHPLACE OF MOTHER (State or country) <u>New Hagerstown</u>		
14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE (Informant) <u>Ed. C. Nally</u> (Address) <u>New Hagerstown, Md.</u>		

16

Filed

1/27 1915 Henry Davis

REGISTRAR

If more blanks are needed, address State Registrar, 6 E. Franklin St., Balto., Requesting V. S. No. 1.

STATE OF MARYLAND  
CERTIFICATE OF DEATHRegistration Dist. No 302

St. — Ward)

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH 1 26, 1915  
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from Dec 15, 1914, to Jan 26, 1915,

that I last saw her alive on Jan 25, 1915,  
and that death occurred on the date stated above, at 7 P. m.

The CAUSE OF DEATH\* was as follows:

General debility and heart disease  
(Duration) yrs. 6 mos. 0 ds.

Contributory Cardiac asthma  
Secondary

(Duration) yrs. 0 mos. 7 ds.  
(Signed) L. Coffey, M. D.  
1/27, 1915 (Address) New Hagerstown

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death yrs. mos. ds. In the State yrs. mos. ds

Where was disease contracted,  
If not at place of death?Former or  
usual residence.

19 PLACE OF BURIAL OR REMOVAL

Bakersville Cemetery Jan 28, 1915

20 UNDERTAKER

N. C. Reichard

DATE OF BURIAL

ADDRESS

Fairplay, Md.

# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

[Approved by U. S. Census and American Public Health Association.]

**Statement of occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary foreman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework, or At Home*, and children, not gainfully employed, as *At school or At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid, etc.* If the occupation has been changed or given up on account of the disease causing death, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.)* For persons who have no occupation whatever, write *None*.

**Statement of cause of death**—Name, first, the disease causing death (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritonaeum, etc., Cancer*.

*oma, Sarcoma, etc. of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); Measles; Whooping cough; Chronic tubular heart disease; Chronic interstitial nephritis, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Examples: Measles (disease causing death), 29 ds.; Bronchopneumonia (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Anæmia," "Anaæmia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsey," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uraæmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "Puerperal septicæmia," "Puerperal peritonitis" etc. State cause for which surgical operation was undertaken. For violent deaths state means of injury and quality as accidental, suicidal, or homicidal, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)*

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RECEIVED

FEB 6 1915

BUREAU, U. S.

## WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

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1 PLACE OF DEATH  
County Washington (No. 152)

1045

STATE OF MARYLAND  
CERTIFICATE OF DEATHRegistration Dist. No. 302Village or City Hagerstown (No. 8)S. Prospect St. 2 Ward

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

## 2 FULL NAME

J. Hilton Orrick

## PERSONAL AND STATISTICAL PARTICULARS

## 3 SEX

Male white

5 SINGLE,  
MARRIED,  
WIDOWED,  
OR DIVORCED  
(Write the word)

Single

## 6 DATE OF BIRTH

January 16, 1915  
(Month) (Day) (Year)

## 7 AGE

If LESS than  
1 day, hrs.  
yrs. mos. 1 ds. OR min. ?

## 8 OCCUPATION

(a) Trade, profession, or  
particular kind of work

None

(b) General nature of industry,  
business, or establishment in  
which employed (or employer)

4

## 9 BIRTHPLACE

(State or country)

Md

## 10 NAME OF FATHER

Rev. J. Hilton Orrick

## 11 BIRTHPLACE OF FATHER

(State or country)

Md

## 12 MAIDEN NAME OF MOTHER

Helen Powell

Md

## 13 BIRTHPLACE OF MOTHER

(State or country)

## 14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Rev. J. Hilton Orrick

(Address)

Hagerstown, Md

## 15

Filed 1-17-15

Henry Davis

REGISTRAR

## MEDICAL CERTIFICATE OF DEATH

## 16 DATE OF DEATH

1 17

, 1915

(Month)

(Day)

(Year)

17 I HEREBY CERTIFY, That I attended deceased from  
January 16, 1915, to January 17, 1915,  
that I last saw him alive on January 17, 1915,  
and that death occurred on the date stated above, at 11 A.M.  
The CAUSE OF DEATH\* was as follows:

Respiratory Failure - Central Nervous

24 hrs. (Duration) yrs. mos. ds.

Contributory Difficult Labor - Breast Presents  
Secondary

(Duration) yrs. mos. ds.

(Signed) H. D. Campbell, M.D.January 17, 1915 (Address) Hagerstown, Md

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

## 18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place yrs. mos. ds. In the State yrs. mos. ds

Where was disease contracted,  
If not at place of death?

Former or usual residence

## 19 PLACE OF BURIAL OR REMOVAL

Hagerstown, Md 1-17-15

DATE OF BURIAL

## 20 UNDERTAKER

C. M. Suter &amp; Son Hagerstown, Md

ADDRESS

# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

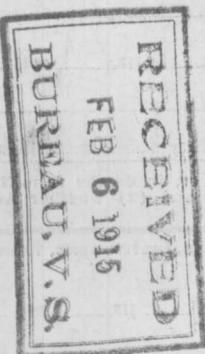
[Approved by U. S. Census and American Public Health Association.]

**Statement of occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner, Cotton mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework, or At Home*, and children, not gainfully employed, as *At school or At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid, etc.* If the occupation has been changed or given up on account of the disease causing death, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.)* For persons who have no occupation whatever, write *None*.

**Statement of cause of death**—Name, first, the disease causing death (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritonaeum, etc., Carcin-*

*oma, Sarcoma, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); Measles; Whooping cough; Chronic tubular heart disease; Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Anemia," "Anæmia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Dility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marsmus," "Old Age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "Puerperal septicæmia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent deaths state means of injury and quality as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sensis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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## WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

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1 PLACE OF DEATH  
County Washington

Village or City Hagerstown (No. 431 Floors)

1046 STATE OF MARYLAND  
CERTIFICATE OF DEATH

Registration Dist. No. 382

St. 5 Ward)

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

## 2 FULL NAME

Myrtle M. Plunkert

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word)
<u>Female</u>	<u>White</u>	<u>single</u>

## 6 DATE OF BIRTH

Oct 4, 1914  
(Month) (Day) (Year)

## 7 AGE

~ yrs. 3 mos. 4 ds.  
If LESS than  
1 day, hrs.  
OR min. ?

## 8 OCCUPATION

(a) Trade, profession, or  
particular kind of work

none

9 BIRTHPLACE  
(State or country)

Md

10 NAME OF  
FATHER

Harry Reeds

11 BIRTHPLACE  
OF FATHER  
(State or country)

Md

12 MAIDEN NAME  
OF MOTHER

Elsie Plunkert

13 BIRTHPLACE  
OF MOTHER  
(State or country)

Md

## 14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Elsie Plunkert

(Address)

Hagerstown

## 15

Filed

1/9-

191

Henry Davis

REGISTRAR

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH  
Jan 8, 1915  
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from  
Jan 3, 1915, to Jan 8, 1915,

that I last saw her alive on Jan 8, 1915,

and that death occurred on the date stated above, at 745 P.M. m.

The CAUSE OF DEATH\* was as follows:

Acute Capillary Bronchitis

(Duration) yrs. mos. 7 ds.  
Contributory Grammes  
Secondary

(Duration) yrs. mos. 2 ds.  
(Signed) F. D. Hoffmeier M. D.  
Jan 9, 1915 (Address) Hagerstown, Md.

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place yrs. mos. ds. In the  
of death yrs. mos. ds. State yrs. mos. ds

Where was disease contracted,  
If not at place of death?

Former or  
usual residence.

## 19 PLACE OF BURIAL OR REMOVAL

Rose Hill Cemetery

DATE OF BURIAL  
Jan 10, 1915

## 20 UNDERTAKER

Watkins & Minard

ADDRESS

Hagerstown

If more blanks are needed, address State Registrar, 6 E. Franklin St., Balto., Requesting V. S. No. 1.

Hoffmeier

# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

[Approved by U. S. Census and American Public Health Association.]

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(a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At Home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the disease causing death, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer* (*retired 6 yrs.*) For persons who have no occupation whatever, write *None*.

## Statement of cause of death—Name, first, the disease

causing death (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Group"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritonaeum, etc.*, *Carcin-*

*oma*, *Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Examples: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "Puerperal septicæmia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent deaths state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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RECEIVED

FEB 6 1916

BUREAU, V. S.

## WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH  
County Washington

Village or City Hagerstown (No. 335)

1047 STATE OF MARYLAND  
CERTIFICATE OF DEATH

Registration Dist. No. 302

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

## 2 FULL NAME

Herman LeRay Robinson

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

male white

4 COLOR OR RACE  
white

5 SINGLE,  
MARRIED,  
WIDOWED,  
OR DIVORCED  
(Write the word)

single

6 DATE OF BIRTH

Feb. 23, 1913  
(Month) (Day) (Year)

7 AGE

1 yrs. 11 mos. 4 ds.  
If LESS than  
1 day, .... hrs.  
OR .... min.?

8 OCCUPATION

(a) Trade, profession, or  
particular kind of work  
None

(b) General nature of industry,  
business, or establishment in  
which employed (or employer)  
None

9 BIRTHPLACE

(State or country)  
Md

10 NAME OF FATHER

Herman L. Robinson

11 BIRTHPLACE OF FATHER

(State or country)  
Del.

12 MAIDEN NAME OF MOTHER

Lattie Eader

13 BIRTHPLACE OF MOTHER

(State or country)  
Md

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)  
Mrs. Lattie Robinson

15

Filed 1-27, 1915  
Henry Davis

REGISTRAR

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

Jan 27, 1915  
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from  
Jan 24, 1915, to Jan 27, 1915

that I last saw him alive on Jan 27, 1915

and that death occurred on the date stated above, at 11:00 a.m.

The CAUSE OF DEATH\* was as follows:

Diphtheria

(Duration) yrs. mos. ds.

Contributory  
Secondary Cardiac Exhaustion

(Duration) yrs. mos. ds.

(Signed) A. P. Stauffer, M. D.  
1-27, 1915 (Address) Hagerstown, Md.

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death yrs. mos. ds. In the State yrs. mos. ds

Where was disease contracted,  
If not at place of death?

Former or  
usual residence

19 PLACE OF BURIAL OR REMOVAL

Rose Hill

DATE OF BURIAL

1-28, 1915

20 UNDERTAKER

Watkins & Minich

ADDRESS

Hagerstown, Md.

# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

[Approved by U. S. Census and American Public Health Association.]

**Statement of occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary foreman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework, or At Home*, and children, not gainfully employed, as *At school or At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid, etc.* If the occupation has been changed or given up on account of the disease causing death, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.)* For persons who have no occupation whatever, write *None*.

**Statement of cause of death**—Name, first, the disease causing death (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Group"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritonaeum, etc., Carcin-*

*oma, Sarcoma, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Examples: Measles (disease causing death), 29 ds.; Bronchopneumonia (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Anæmia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsey," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL septicæmia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. For violent deaths state means of INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)*

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.

RECEIVED

FEB 6 1915

BUREAU.V.S.

## WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

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1 PLACE OF DEATH  
County Washington  
Village or City Big Pool

1048

STATE OF MARYLAND  
CERTIFICATE OF DEATH

Registered No. 319

St: Ward)

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

## FULL NAME

Cassandra E. Groof

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE White 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word) widowed

## 6 DATE OF BIRTH

Oct. 3, 1842  
(Month) (Day) (Year)

## 7 AGE

72 yrs. 3 mos. 8 ds. OR min. ?

If LESS than  
1 day, hrs.  
OR min. ?

## 8 OCCUPATION

(a) Trade, profession, or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

Housewife

9 BIRTHPLACE  
(State or country)

Maryland

## PARENTS

## 10 NAME OF FATHER

F. W. Weddell

11 BIRTHPLACE OF FATHER  
(State or country)

Maryland

## 12 MAIDEN NAME OF MOTHER

Mary Garver

13 BIRTHPLACE OF MOTHER  
(State or country)

Maryland

## 14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Loie R. Manafort

(Address)

Cherry Run, W. Va.

## 15

Filed

Jan. 13, 1915

W. B. Hull

REGISTRAR

## MEDICAL CERTIFICATE OF DEATH

## 16 DATE OF DEATH

Jan. 11, 1915  
(Month) (Day) (Year)

I HEREBY CERTIFY, That I attended deceased from

Nov. 3, 1914, to Jan. 11, 1915,  
that I last saw her alive on Nov. 3, 1914

and that death occurred on the date stated above, at 10 P. m.

The CAUSE OF DEATH\* was as follows:

Malignant tumor of intestines

(Duration) 1 yrs. mos. ds.

Contributory  
(Secondary)

(Duration) yrs. mos. ds.

(Signed) Theo. Boose, M. D.  
Jan. 12, 1915 (Address) Wm. Port, Md.

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

## 18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

## 19 PLACE OF BURIAL OR REMOVAL

Shanktown Cemetery

## 20 UNDERTAKER

Frank Bross ton

## DATE OF BURIAL

Jan. 14, 1915

## ADDRESS

Clearing, Md.

REVISED UNITED STATES STANDARD  
CERTIFICATE OF DEATH

[Approved by U. S. Census and American Public Health Association]

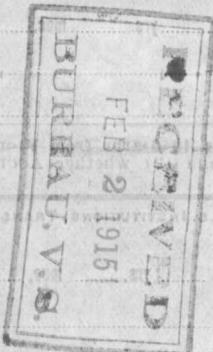
1

**Statement of occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Pianist*, *Physician*, *Composer*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At Home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the disease causing death, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.)*. For persons who have no occupation whatever, write *None*.

**Statement of cause of death**—Name, first, the disease causing death (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritonaeum*, etc. *Carcin-*

statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer*, *Farm laborer*, *Laborer*—*Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At Home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the disease causing death, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer* (*retired 6 yrs.*). For persons who have no occupation whatever, write *None*.

valvular heart disease; Chronic interstitial nephritis. etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Anæmia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Con-genital," "Senile," etc.), "Dropsey," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Malaria," "Old Age," "Shock," "Tetraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL septicæmia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. For violent deaths state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train-accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)



## MARGIN RESERVED FOR BINDING

## WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

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1 PLACE OF DEATH  
County Washington

Village or City Clearspring M. R. D. 2 (No. \_\_\_\_\_)

1049

STATE OF MARYLAND  
CERTIFICATE OF DEATHRegistration Dist. No. 302

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

## 2 FULL NAME

Bessie Nola Rubeck.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female. 4 COLOR OR RACE White 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED Single  
(Write the word)

## 6 DATE OF BIRTH

Oct. 12, 1915  
(Month) (Day) (Year)

## 7 AGE

3 yrs. 15 mos. 15 ds.  
If LESS than  
1 day, hrs.  
OR min. ?

## 8 OCCUPATION

(a) Trade, profession, or  
particular kind of work.  
None.  
1000

## 9 BIRTHPLACE

(State or country)

## 10 NAME OF FATHER

Frederick Rubeck.

## 11 BIRTHPLACE OF FATHER

(State or country)

## 12 MAIDEN NAME OF MOTHER

Sadie Wiley.

## 13 BIRTHPLACE OF MOTHER

(State or country)

Clearspring M. R. D. 2.

## 14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Frederick Rubeck.(Address) Clearspring M. R. D. 2.

15

Filed July 26, 1915. David S. Miller

REGISTRAR

If more blanks are needed, address State Registrar, 6 E. Franklin St., Balto., Requesting V. S. No. 1.

## MEDICAL CERTIFICATE OF DEATH

## 16 DATE OF DEATH

Jan 26, 1915  
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from

191\_\_\_\_, to 191\_\_\_\_, 191\_\_\_\_

that I last saw h. alive on 191\_\_\_\_, 191\_\_\_\_

and that death occurred on the date stated above, at m.

The CAUSE OF DEATH\* was as follows:

I do not know cause of death as it was sudden without any attendance. I was dead when I arrived.

(Duration) yrs. mos. ds.

Contributory  
Secondary

(Duration) yrs. mos. ds.

(Signed) Harry B. Chappell, M. D.

Jan 27, 1915 (Address) Waukegan, Ill.

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

## 18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, If not at place of death?

Former or usual residence.

## 19 PLACE OF BURIAL OR REMOVAL

Bliss Valley DATE OF BURIAL Jan 28, 1915

## 20 UNDERTAKER

Frank Brooks ADDRESS Clear Spring

# REVISED UNITED STATES STANDARD

## CERTIFICATE OF DEATH

[Approved by U. S. Census and American Public Health Association.]

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(a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At Home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the disease causing death, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer* (*retired 6 yrs.*) For persons who have no occupation whatever, write *None*.

**Statement of cause of death**—Name, first, the disease causing death (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Oerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Group"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritonaeum, etc., Cancer-*

*oma, Sarcoma, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Examples: Measles (disease causing death), 29 ds.; Bronchopneumonia (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Anemia," "Anæmia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "Puerperal septicæmia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent deaths state means of injury and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide. The nature of the injury, as fracture of skull, and consequences (e. g., *scpsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)*

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RECEIVED

FEB 5 1915

BUREAU, U. S.

## WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

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1 PLACE OF DEATH  
County WASHINGTON

Village or City HAGERSTOWN (No. 479), POTOMAC AVE. St. 5<sup>th</sup> Ward)

1050 STATE OF MARYLAND  
CERTIFICATE OF DEATH

Registration Dist. No. 302

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

40

2 FULL NAME MRS. ALICE M. RYDER

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the WIDOW)
FEMALE	WHITE	WIDOW

6 DATE OF BIRTH  
DECEMBER 24<sup>th</sup>, 1858.  
(Month) (Day) (Year)

7 AGE  
56 yrs. 0 mos. 19 ds. If LESS than  
1 day, hrs.  
OR min. ?

8 OCCUPATION  
(a) Trade, profession, or  
particular kind of work.  
AT HOME  
(b) General nature of industry,  
business, or establishment in  
which employed (or employer)  
AT HOME

9 BIRTHPLACE  
(State or country)  
MARYLAND. H

10 NAME OF  
FATHER  
STEPHEN G. MARTIN

11 BIRTHPLACE  
OF FATHER  
(State or country)  
MARYLAND.

12 MAIDEN NAME  
OF MOTHER  
ANNA FUNK.

13 BIRTHPLACE  
OF MOTHER  
(State or country)  
MARYLAND.

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) ANNA RYDER SEIBERT

(Address) # 479 POTOMAC AVE.

15 Filed 1-16-1915 Henry Davis

REGISTRAR

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH Jan 13<sup>th</sup>, 1915  
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from  
January 18, 1914, to Jan 13, 1915.

that I last saw her alive on Jan 13, 1915.

and that death occurred on the date stated above, at 11:30 P.M.

The CAUSE OF DEATH\* was as follows:

*Benign tumor of Stomach*  
(Duration) 2 yrs. mos. ds.

Contributory  
Secondary

*W. R. Ryder, M.D.*  
(Duration) yrs. mos. ds.  
(Signed) Jan 14<sup>th</sup>, 1915. (Address) Hagerstown

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted,  
If not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

WAYNESBORO, PENNA. JAN. 15<sup>th</sup>, 1915

20 UNDERTAKER ADDRESS

C. M. SUTER & SON HAGERSTOWN MD

# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

[Approved by U. S. Census and American Public Health Association.]

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(a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At Home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the disease causing death, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.)*. For persons who have no occupation whatever, write *None*.

**Statement of cause of death**—Name, first, the disease causing death (the primary affection) with respect to time and causation, using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia", unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum, etc., Cancer*.

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RECEIVED

FEB 6 1915

BUHLAU, W.S.

## WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1051

✓ 80 ✓ 302

STATE OF MARYLAND  
CERTIFICATE OF DEATH

Registration Dist. No. 302

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

**1 PLACE OF DEATH**  
County Washington

Village or City Hagerstown (No. 32, E. Wash St St; 3rd Ward)

**2 FULL NAME** Andrew J. Schindel

---

**PERSONAL AND STATISTICAL PARTICULARS**

<b>3 SEX</b> Male	<b>4 COLOR OR RACE</b> W	<b>5 SINGLE, MARRIED, WIDOWED, OR DIVORCED</b> Widower (Write the word)
<b>6 DATE OF BIRTH</b>		Jan 17, 1828 (Month) (Day) (Year)
<b>7 AGE</b>		86 yrs. 6 mos. 23 ds. If LESS than 1 day, hrs. OR min. ?
<b>8 OCCUPATION</b> (a) Trade, profession, or particular kind of work. Retired Merchant		
(b) General nature of industry, business, or establishment in which employed (or employer)		
<b>9 BIRTHPLACE</b> (State or country)		
<b>10 NAME OF FATHER</b> S. Schindel		
<b>11 BIRTHPLACE OF FATHER</b> (State or country)		
<b>12 MAIDEN NAME OF MOTHER</b> Julia Hade		
<b>13 BIRTHPLACE OF MOTHER</b> (State or country)		
<b>14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE</b> (Informant) Mrs Purvis Taylor (Address) Phila.		
<b>15</b> Filed 1-23-1915 Henry Davis		
REGISTRAR		

---

**MEDICAL CERTIFICATE OF DEATH**

**16 DATE OF DEATH**  
/ 21, 1915  
(Month) (Day) (Year)

**17** I HEREBY CERTIFY, That I attended deceased from Jan 21, 1915, to Jan 21, 1915,  
that I last saw him alive on Jan 21, 1915,  
and that death occurred on the date stated above, at 945 A.M.  
The CAUSE OF DEATH\* was as follows:  
Olding Petaries

(Duration) yrs. mos. ds.

**Contributory**  
(Secondary)

(Duration) yrs. mos. ds.

(Signed) J. H. Campbell, M.D.  
Jan 21, 1915 (Address) Hagerstown, Md.

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

**18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)**

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

**19 PLACE OF BURIAL OR REMOVAL**  
Rose Hill Cem Jan 23, 1915

**20 UNDERTAKER**  
Kraiss Bros ADDRESS 38 E. Wash St

# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

[Approved by U. S. Census and American Public Health Association.]

**Statement of occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry; and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer*, *Farm laborer*, *Laborer—Candy*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers*—who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At Home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the disease causing death, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer* (*retired 6 yrs.*). For persons who have no occupation whatever, write *None*.

**Statement of cause of death**—Name, first, the disease causing death (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Group"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma*. *Sarcoma*, etc., of ..... (name origin; "Ganglion" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Examples: *Measles* (disease causing death), *29 d.s.*; *Bronchopneumonia* (secondary), *10 d.s.* Never report mere symptoms or terminal conditions, such as "Anæmia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Malnutrition," "Old Age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "Puerperal septicæmia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent deaths state means of injury and quality as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: "Accidental drowning"; *Struck by railway train*—accident; *Revolver wound of head*—homicide; *Poisoned by carbolic acid*—probably suicide. The nature of the injury, as fracture or skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.

RECEIVED

FEB 6 1915

BUREAU, V.S.

## WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH  
County Washington

Village or City Cleaspring R.R. (No.)

1052

STATE OF MARYLAND  
CERTIFICATE OF DEATHRegistration Dist. No. 303

St. \_\_\_\_\_ Ward \_\_\_\_\_

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME Clara Schnebly

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX Mrs. 4 COLOR OR RACE white 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED Married  
(Write the word)

## 6 DATE OF BIRTH

Oct. 7, 1879  
(Month) (Day) (Year)

## 7 AGE

35 yrs. 2 mos. 30 ds. If LESS than  
1 day, 4 hrs.  
OR min. ?

## 8 OCCUPATION

(a) Trade, profession, or  
particular kind of work. Housewife  
(b) General nature of industry,  
business, or establishment in  
which employed (or employer)

9 BIRTHPLACE  
(State or country)Penna.PARENTS  
10 NAME OF FATHERLevi Meyers11 BIRTHPLACE OF FATHER  
(State or country)Penna

## 12 MAIDEN NAME OF MOTHER

Amanda B. Bricker13 BIRTHPLACE OF MOTHER  
(State or country)Penna

## 14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

L. Allen Schnebly

(Address)

Cleaspring, Md.

15

Filed Jan. 9<sup>th</sup>, 1915—Levi M. Foyler  
Deputy Reg. No. 4303 REGISTRAR

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH Jan 6, 1915  
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from  
Jan 6, 1915, to Jan 6, 1915,  
that I last saw her alive on Jan 6, 1915

and that death occurred on the date stated above, at 8 P.M.

The CAUSE OF DEATH\* was as follows:

Past Pains & Headaches  
4 hours.  
(Duration) yrs. mos. ds.

Contributory  
Secondary

(Duration) yrs. mos. ds.  
(Signed) Henry B. Chynoweth, M. D.  
Jan 7, 1915 (Address) Pleasant Rd. #45

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

## 18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted,  
If not at place of death?

Former or  
usual residence

19 PLACE OF BURIAL OR REMOVAL St. Paul's Cemetery DATE OF BURIAL Jan. 9<sup>th</sup>, 1915

20 UNDERTAKER Frank Bros' ADDRESS Cleaspring, Md.

If more blanks are needed, address State Registrar, 6 E. Franklin St., Balt., Requesting V. S. No. 1.

# REVISED UNITED STATES STANDARD

## CERTIFICATE OF DEATH

[Approved by U. S. Census and American Public Health Association.]

**Statement of occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples:

(a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At Home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the disease causing death, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.)* For persons who have no occupation whatever, write *None*.

**Statement of cause of death**—Name, first, the disease causing death (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Group"); *Typhoid* fever (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritonaeum, etc., carcin-*

*oma, Sarcoma, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: Measles (disease causing death), 29 ds.; Bronchopneumonia (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Anæmia," "Anæmia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Con genital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "Puerperal septicemia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent deaths state means of injury and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide. The nature of the injury, as fracture of skull, and consequences (e. g., sepsis, tetanus) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)*

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RECEIVED

FEB 5 1915

BUREAU, U. S.

## WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

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1053

1 PLACE OF DEATH **Washington** (No. 151)

County **Lydia** (No. 134)

Village or City **Geo. B. Shank Jr. (Illegitimate)**

2 FULL NAME

3 SEX **Male** 4 COLOR OR RACE **white** 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED **Single**  
(Write the word)

6 DATE OF BIRTH **Jan 12, 1915**  
(Month) (Day) (Year)

7 AGE **— yrs. — mos. — ds.** If LESS than 1 day, **5** hrs. OR min. ?

8 OCCUPATION  
(a) Trade, profession, or particular kind of work.  
(b) General nature of industry, business, or establishment in which employed (or employer) **Waiter**

9 BIRTHPLACE **MD**  
(State or country)

10 NAME OF FATHER **?**

11 BIRTHPLACE OF FATHER **?**  
(State or country)

12 MAIDEN NAME OF MOTHER **Bessie M. Shank**

13 BIRTHPLACE OF MOTHER **MD**  
(State or country)

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE  
(Informant) **Katie Shank**  
(Address) **Lydia**

15 Filed **Jan 13, 1915** By **V. M. Richard**  
Local REGISTRAR

St. **Ward** **311** [If death occurred in a hospital or institution, give its NAME instead of street and number.]

16 DATE OF DEATH **Jan 13, 1915**  
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from **Jan 13, 1915** to **Jan 13, 1915**, that I last saw him alive on **Jan 12, 1915**, and that death occurred on the date stated above, at **2 a.m.** The CAUSE OF DEATH\* was as follows: **Debility owing to pneumonia which at 6th month** (Duration) **yrs. mos. ds.**

Contributory  
Secondary

(Signed) **V. M. Richard, M. D.** (Address) **Fair Play** (Duration) **yrs. mos. ds.**

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)  
At place of death **yrs. mos. ds.** In the State **yrs. mos. ds.**  
Where was disease contracted, if not at place of death?  
Former or usual residence.

19 PLACE OF BURIAL OR REMOVAL **Fair Play** DATE OF BURIAL **Jan 13, 1915**

20 UNDERTAKER **V. M. Richard** ADDRESS **Fair Play**

If more blanks are needed, address State Registrar, 6 E. Franklin St., Balt., Requesting V. S. No. 1.

# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

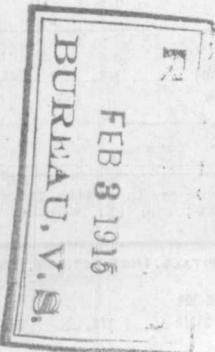
[Approved by U. S. Census and American Public Health Association.]

**Statement of occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter*, *Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At Home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the disease causing death, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.)* For persons who have no occupation whatever, write *None*.

**Statement of cause of death**—Name, first, the disease causing death (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Group"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritonaeum, etc.*, *Carcin-*

*oma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Examples: *Measles* (disease causing death), 29 d.; *Bronchopneumonia* (secondary), 10 d. Never report mere symptoms or terminal conditions, such as "Anæmia," "Anæmia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL septicæmia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. For violent deaths state means of injury and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *scrosis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.



## WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

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1 PLACE OF DEATH  
County Washington

Village or City Hagerstown (No. 318) St. 5 Ward)

1054

STATE OF MARYLAND  
CERTIFICATE OF DEATH

Registration Dist. No.

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

## 2 FULL NAME

Steve bony  
Steph Child of boy & Mary Shetron

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word)
female	white	S

## 6 DATE OF BIRTH

....., 1  
(Month) (Day) (Year)

## 7 AGE

..... yrs. .... mos. .... ds. If LESS than  
1 day, .... hrs.  
OR .... min. ?

## 8 OCCUPATION

(a) Trade, profession, or  
particular kind of work.  
(b) General nature of industry,  
business, or establishment in  
which employed (or employer)

9 BIRTHPLACE  
(State or country)10 NAME OF  
FATHER

Roy Shetron  
Penns.

11 BIRTHPLACE  
OF FATHER  
(State or country)

May Golden  
Maryland

12 MAIDEN NAME  
OF MOTHER

13 BIRTHPLACE  
OF MOTHER  
(State or country)

## 14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Roy Shetron  
(Address) 318 Singanore ave

15 Filed 1915

REGISTRAR

## MEDICAL CERTIFICATE OF DEATH

## 16 DATE OF DEATH

....., 191  
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from

Jan 15, 1915, to Jan 16, 1915,

that I last saw h. alive on Steph bony, 1915.

and that death occurred on the date stated above, at m.

The CAUSE OF DEATH is as follows:

From fall of master  
3 days off, Child  
about fell down

(Duration) .... yrs. .... mos. .... ds.

## Contributory

Secondary

Accident (Duration) .... yrs. .... mos. .... ds.  
(Signed) 1/15/15, 1915 (Address) Hagerstown, M. D.

\*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

## 18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death .... yrs. .... mos. .... ds. In the State .... yrs. .... mos. .... ds

Where was disease contracted, if not at place of death?

Former or usual residence.

## 19 PLACE OF BURIAL OR REMOVAL

Rose Hill Cemetery (Date of Burial) Jan 15, 1915

## 20 UNDERTAKER

C. M. Luter & Son (Address) Hagerstown

# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

[Approved by U. S. Census and American Public Health Association.]

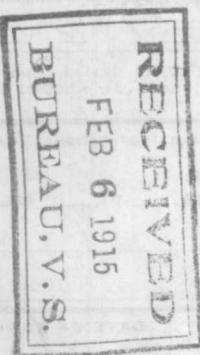
**Statement of occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter*, *Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary foreman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples:

(a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At Home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the disease causing death, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.)* For persons who have no occupation whatever, write *None*.

**Statement of cause of death**—Name, first, the disease causing death (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Group"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum, etc., Cancer*.

*oma*, *Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic vulvar heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Examples: *Measles* (disease causing death), *29 d.s.*; *Bronchopneumonia* (secondary), *10 d.s.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Malaria," "Old Age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL septicæmia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. For violent deaths state means of INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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1 PLACE OF DEATH  
County Washington

Village or City Ernestville (No. )

1055

STATE OF MARYLAND  
CERTIFICATE OF DEATHRegistration Dist. No. 314St. Ward)

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

## 2 FULL NAME

Daniel H. Shives

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX <u>Male</u>	4 COLOR OR RACE <u>white</u>	5 SINGLE, MARRIED, WIDOWED, OR DIVORCED <u>Married</u> (Write the word)
-------------------	------------------------------	--

## 6 DATE OF BIRTH

Oct. 29, 1834  
(Month) (Day) (Year)

## 7 AGE

80 yrs. 8 mos. 15 ds.

If LESS than  
1 day, \_\_\_\_ hrs.  
OR \_\_\_\_ min. ?

## 8 OCCUPATION

(a) Trade, profession, or particular kind of work

Laborer

(b) General nature of industry, business, or establishment in which employed (or employer)

9 BIRTHPLACE  
(State or country)Md

## 10 NAME OF FATHER

Robert Shives11 BIRTHPLACE OF FATHER  
(State or country)Md

## 12 MAIDEN NAME OF MOTHER

Lydia Leveneigh13 BIRTHPLACE OF MOTHER  
(State or country)Unknown

## 14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Elizabeth Shives

(Address) Big Pool Md

15

Filed

191

REGISTRAR

## MEDICAL CERTIFICATE OF DEATH

## 16 DATE OF DEATH

Jan. 13, 1915  
(Month) (Day) (Year)

## 17 I HEREBY CERTIFY, That I attended deceased from

191, to 191, 191

that I last saw him alive on 191, 191

and that death occurred on the date stated above, at 8 a.m.

The CAUSE OF DEATH\* was as follows:

Ortho and General debility

(Duration) 7 yrs. mos. ds.

Contributory  
Secondary

(Duration) 1 yrs. mos. ds.  
(Signed) W. B. Hull W. B. Hull, M. D.

191 (Address) Big Pool Md

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

## 18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death 191 yrs. mos. ds. In the State 191 yrs. mos. ds.

Where was disease contracted,

If not at place of death?

Former or usual residence.

## 19 PLACE OF BURIAL OR REMOVAL

Shanktown Cemetery Jan. 15, 1915

## 20 UNDERTAKER

Franky Bros & Co., Clear Spring

ADDRESS

# REVISED UNITED STATES STANDARD

## CERTIFICATE OF DEATH

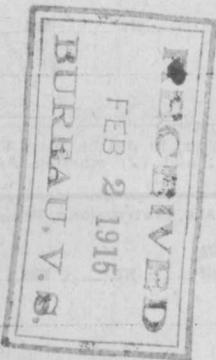
[Approved by U. S. Census and American Public Health Association.]

**Statement of occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner, (b) Cotton mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework, or At Home*, and children, not gainfully employed, as *At school or At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid, etc.* If the occupation has been changed or given up on account of the disease causing death, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.)* For persons who have no occupation whatever, write *None*.

**Statement of cause of death**—Name, first, the disease causing death (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum, etc., Carcin-*

*oma, Sarcoma, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: Measles (disease causing death), 29 d.; Bronchopneumonia (secondary), 10 d. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Con genital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "Puerperal septicæmia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent deaths state means of injury and quality as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide. The nature of the injury, as fracture of skull, and consequences (e. g., *spasis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)*

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.



## WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See Instructions on back of certificate.

1 PLACE OF DEATH  
County WASHINGTON

V 104  
1056 STATE OF MARYLAND  
CERTIFICATE OF DEATH  
Registration Dist. No. 302  
Village or City HAGERSTOWN (No. 44, Street WEST SIDE AVE. St. 1<sup>1</sup> Ward)

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME CLIFFORD LEROY SHIPLEY

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX <u>MALE</u>	4 COLOR OR RACE <u>WHITE</u>	5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the <u>SINGLE</u> )
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## 6 DATE OF BIRTH

DECEMBER 30<sup>th</sup>, 1914.  
(Month) (Day) (Year)

## 7 AGE

— yrs. — mos. 14 ds. If LESS than  
1 day, .... hrs.  
OR min. ?

## 8 OCCUPATION

(a) Trade, profession, or particular kind of work. NONE  
(b) General nature of industry, business, or establishment in which employed (or employer) NONE

9 BIRTHPLACE  
(State or country)

MARYLAND.

## 10 NAME OF FATHER

HARRY S SHIPLEY

## 11 BIRTHPLACE OF FATHER

(State or country) MARYLAND.

## 12 MAIDEN NAME OF MOTHER

CARRIE SNYDER

## 13 BIRTHPLACE OF MOTHER

(State or country) MARYLAND.

## 14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) HARRY S SHIPLEY

(Address) #44 WES SIDE AVE.

## 15

Filed 1/13<sup>th</sup>, 1915

*Henry Davis*  
REGISTRAR

## MEDICAL CERTIFICATE OF DEATH

## 16 DATE OF DEATH

JAN. 13<sup>th</sup>, 1915, 1915  
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from

JAN. 12<sup>th</sup>, 1915, to JAN. 12<sup>th</sup>, 1915, 1915  
that I last saw him alive on JAN. 12<sup>th</sup>, 1915, 1915

and that death occurred on the date stated above, at 1 am, 1915

The CAUSE OF DEATH\* was as follows:

*Enter - Colitis*

(Duration) unknown yrs. mos. ds.

Contributory  
Secondary

(Duration) 1 yrs. mos. ds.

(Signed) H. S. Herman, M. D.  
JAN. 13<sup>th</sup>, 1915 (Address) Hagerstown MD

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

## 18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence.

## 19 PLACE OF BURIAL OR REMOVAL

KEEDYSVILLE, MD.

DATE OF BURIAL  
JAN. 14<sup>th</sup>, 1915

## 20 UNDERTAKER

C. M. SUTER & SON

ADDRESS  
HAGERSTOWN MD.

# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

[Approved by U. S. Census and American Public Health Association.]

**Statement of occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples:

(a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At Home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the disease causing death, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer* (*retired 6 yrs.*) For persons who have no occupation whatever, write *None*.

**Statement of cause of death**—Name, first, the disease causing death (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Group"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum, etc., Cancer*.

*oma*, *Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 d.s.*; *Bronchopneumonia* (secondary), *10 d.s.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "Puerperal septicemia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent deaths state means of INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *scpsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.

RECEIVED

FEB 6 1915

BUREAU, V. S.

## WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH  
County Washington

Village or City Kensington

1062 STATE OF MARYLAND  
CERTIFICATE OF DEATH

Registration Dist. No. 316

St. Ward)

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME Charles Smith

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE White 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED Married (Write the word)

## 6 DATE OF BIRTH

Jan 28, 1915  
(Month) (Day) (Year)

## 7 AGE

..... yrs. .... mos. .... ds. If LESS than 1 day, .... hrs. OR ..... min. ?

## 8 OCCUPATION

(a) Trade, profession, or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer) None

## 9 BIRTHPLACE

(State or country) Kensington MD

## PARENTS

10 NAME OF FATHER Charles Smith

11 BIRTHPLACE OF FATHER (State or country) None

12 MAIDEN NAME OF MOTHER Mary Smith

13 BIRTHPLACE OF MOTHER (State or country) None

## 14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Charles Smith

(Address) Kensington

15 Filed Jan 30, 1915 - HN Drumm

REGISTRAR

## MEDICAL CERTIFICATE OF DEATH

## 16 DATE OF DEATH

Jan 28, 1915  
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from

, 191..... to ..... 191.....

that I last saw h..... alive on ..... 191.....

and that death occurred on the date stated above, at ..... 1/2..... a.m.

The CAUSE OF DEATH\* was as follows:

Pyromotoric Fracture  
about 3 mo.

(Duration) yrs. mos. ds.  
Still-born

Contributory  
Secondary

(Duration) yrs. mos. ds.

(Signed) H. N. Drumm, M. D.  
Jan 30, 1915 (Address) Kensington

\* State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

## 18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death ..... yrs. .... mos. .... ds. In the State ..... yrs. .... mos. .... ds

Where was disease contracted, if not at place of death?

Former or usual residence.

## 19 PLACE OF BURIAL OR REMOVAL

On premises DATE OF BURIAL Jan 29, 1915

## 20 UNDERTAKER

ADDRESS

# REVISED UNITED STATES STANDARD

## CERTIFICATE OF DEATH

[Approved by U. S. Census and American Public Health Association.]

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**Statement of cause of death**—Name, first, the disease causing death (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritonaeum, etc.*, *Carcinoma*, *Sarcoma*, etc. of..... (name origin); "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Examples: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Mastitis," "Old Age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "Puerperal septicæmia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent deaths state means of injury and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train*—*accident*; *Revolver wound of head*—*homicide*; *Poisoned by carbolic acid*—*probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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RECEIVED

FEB 8 1915

BUREAU, V.S.

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## 1 PLACE OF DEATH

County Washington

1063

34

STATE OF MARYLAND  
CERTIFICATE OF DEATHRegistration Dist. No. 1St. 302 Ward

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

Village or City Hagerstown (No. 713 South Patowmack)

2 FULL NAME Paul Stanley Springer

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX male 4 COLOR OR RACE white 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED single  
(Write the word)

## 6 DATE OF BIRTH

Feb. 19, 1903  
(Month) (Day) (Year)

## 7 AGE

11 yrs. 10 mos. 16 ds. If LESS than 1 day, \_\_\_\_\_ hrs.  
OR min. ?

## 8 OCCUPATION

(a) Trade, profession, or particular kind of work.

at home

(b) General nature of industry, business, or establishment in which employed (or employer)

## 9 BIRTHPLACE

(State or country) Maryland

## 10 NAME OF FATHER

William H. Springer

## 11 BIRTHPLACE OF FATHER

(State or country) Maryland

## 12 MAIDEN NAME OF MOTHER

Martha E. Swope

## 13 BIRTHPLACE OF MOTHER

(State or country) Maryland

## 14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) W. H. Springer

(Address) 713 S. Patowmack, Hagerstown, Md.

## 15

Filed 1/5-5, 1915

REGISTRAR

## MEDICAL CERTIFICATE OF DEATH

## 16 DATE OF DEATH

Jan 3, 1915  
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from Apr 6, 1914, to Jan 3, 1915

that I last saw him alive on Jan 2, 1915

and that death occurred on the date stated above, at 10 a.m.

The CAUSE OF DEATH\* was as follows:

Tuberculosis of spine  
and heart

(Duration) 6 yrs. 6 mos. 0 ds.

Contributory  
Secondary

Dropsey and Spleen

(Duration) 0 yrs. 0 mos. 0 ds.

(Signed) W. H. Springer

(Address) 713 S. Patowmack, Hagerstown, Md.

\* State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

## 18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place \_\_\_\_\_ In the \_\_\_\_\_  
of death \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds. State \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds

Where was disease contracted,  
If not at place of death? \_\_\_\_\_

Former or  
usual residence.

## 19 PLACE OF BURIAL OR REMOVAL

Hagerstown, Md. - Jan. 5, 1915

DATE OF BURIAL

## 20 UNDERTAKER

H. Coffman ADDRESS Hagerstown, Md.

If more blanks are needed, address State Registrar, 6 E. Franklin St., Balto., Requesting V. S. No. 1.

# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

[Approved by U. S. Census and American Public Health Association.]

**Statement of occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples:

(a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc. without more precise specification as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At Home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the disease causing death, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer* (*retired 6 yrs.*) For persons who have no occupation whatever, write *None*.

**Statement of cause of death**—Name, first, the disease causing death (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritonaeum*, etc., *Carcin-*

*oma*, *Sarcoma*, etc., of..... (name origin); "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Mesles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Anæmia," "Anaæmia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsey," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "Puerperal septicæmia," "Puerperal peritonitis," etc. State cause for ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *scpsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.

RECEIVED

FEB 6 1915

BUREAU, V. S.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See Instructions on back of certificate.

## 1 PLACE OF DEATH

County WashingtonVillage or City Pleasantville (No. 5)

## 2 FULL NAME

Bradley Smith Thompson1057 STATE OF MARYLAND  
CERTIFICATE OF DEATHRegistered No. 310St. Ward

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX <u>Male</u>	4 COLOR OR RACE <u>white</u>	5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word)
-------------------	------------------------------	---

## 6 DATE OF BIRTH

Jan. 30, 1915  
(Month) (Day) (Year)

## 7 AGE

Still born  
yrs. mos. ds. If LESS than  
1 day, hrs.  
OR min. ?

## 8 OCCUPATION

(a) Trade, profession, or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

9 BIRTHPLACE  
(State or country)Md

## 10 NAME OF FATHER

John F. Thompson11 BIRTHPLACE OF FATHER  
(State or country)Md

## 12 MAIDEN NAME OF MOTHER

Rhoda Agnes Hoffman13 BIRTHPLACE OF MOTHER  
(State or country)West Va

## 14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Dr B B Ranson(Address) Harpers Ferry, W. Va.

## 15

Filed Jan 30, 1915 Q.M. Hoffmann  
Local REGISTRAR

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH Jan. 30  
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from

that I last saw h alive on , 191 , to , 191 ,

and that death occurred on the date stated above, at , 191 ,

The CAUSE OF DEATH\* was as follows:

Still born

(Duration) yrs. mos. ds.

Contributory  
(Secondary)

(Duration) yrs. mos. ds.

(Signed) B. B. Ranson MD, M. D.  
Jan 30, 1915 (Address) Harpers Ferry, W. Va.

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

## 18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

## 19 PLACE OF BURIAL OR REMOVAL

Samples ManorDATE OF BURIAL  
Jan 31, 1915

## 20 UNDERTAKER

John McArthurADDRESS  
Colivar, West Va

# REVISED UNITED STATES STANDARD

## CERTIFICATE OF DEATH

[Approved by U. S. Census and American Public Health Association.]

**Statement of occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Tealer," etc., without more precise specification, as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At Home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the disease causing death, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.)*. For persons who have no occupation whatever, write *None*.

**Statement of cause of death**—Name, first, the disease causing death (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Group"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc. *Carcin-*

*oma*, *Sarcoma*, etc., of ..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Examples: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Anesthesia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Delirium" ("Confusional," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Mastitis," "Old Age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "Puerperal septicemia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent deaths state means of injury and qualify as accidental, suicidal, or homicidal, or as probably such, if impossible to determine definitely. Examples: "Accidental drowning"; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondences. All the data is essential and must be obtained before the certificate is permanently filed.

<b>RECEIVED</b>
FEB 2 1915
<b>BUREAU, V. S.</b>

## MARGIN RESERVED FOR BINDING

## WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH  
County Washington

Village or City Hagerstown (No. 38, W. Potowac St., 3 " Ward)

## 2 FULL NAME

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE White 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED Widow  
(Write the word)

6 DATE OF BIRTH Mar. 7, 1842  
(Month) (Day) (Year)

7 AGE 72 yrs. 10 mos. 15 ds. If LESS than  
1 day, \_\_\_\_ hrs.  
OR \_\_\_\_ min. ?

8 OCCUPATION Housework  
(a) Trade, profession, or  
particular kind of work  
(b) General nature of industry,  
business, or establishment in  
which employed (or employer) 11 11

9 BIRTHPLACE Virginia  
(State or country)

10 NAME OF FATHER Michael Englebright  
11 BIRTHPLACE OF FATHER Md.  
(State or country)

12 MAIDEN NAME OF MOTHER McKeeown

13 BIRTHPLACE OF MOTHER 11  
(State or country)

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Miss Lurie Arty  
(Address) 38 W. Potowac St.

15 Filed 1/22, 1915 Henry Davis

REGISTRAR

STATE OF MARYLAND  
CERTIFICATE OF DEATH

Registration Dist. No. 302

[If death occurred in  
a hospital or institution,  
give its NAME instead  
of street and number.]

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH Jan 22, 1915  
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from  
Jan 15, 1915, to Jan 22, 1915,

that I last saw her alive on Jan 22, 1915,

and that death occurred on the date stated above, at 10 A.M.

The CAUSE OF DEATH\* was as follows:

Embolism  
(Duration) yrs. mos. 7 ds.

Contributory Cardiac Exhaustion  
Secondary

(Duration) yrs. mos. ds.

(Signed) A. O. Slaner, M. D.  
Jan 27, 1915 (Address) Hagerstown, Md.

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted,  
If not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL Martinsburg, W. Va. DATE OF BURIAL 1/23, 1915

20 UNDERTAKER B. M. Water Boy ADDRESS Hagerstown, Md.

If more blanks are needed, address State Registrar, 6 E. Franklin St., Balto., Requesting V. S. No. 1.

# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

[Approved by U. S. Census and American Public Health Association.]

**Statement of occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter*, *Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary foreman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples:

(a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At Home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the disease causing DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.)* For persons who have no occupation whatever, write *None*.

**Statement of cause of death**—Name, first, the DISEASE causing DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Group"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia", unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcin-*

*oma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. For violent deaths state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.

**RECEIVED**

FEB 6 1915

BUREAU, V. S.

## WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH  
County Washington

Village or City Hagerstown (No. 5)

2 FULL NAME Still born child Thos Y Mary Washington

1059 STATE OF MARYLAND  
CERTIFICATE OF DEATH

Registration Dist. No. 302

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

3 SEX	4 COLOR OR RACE	5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word)
<u>Female</u>	<u>colored</u>	<u>Single</u>

6 DATE OF BIRTH  
Jan 1, 1915  
(Month) (Day) (Year)

7 AGE  
— yrs. — mos. — ds. If LESS than  
1 day, hrs. OR min. ?

8 OCCUPATION  
(a) Trade, profession, or  
particular kind of work.  
—  
(b) General nature of industry,  
business, or establishment in  
which employed (or employer) —

9 BIRTHPLACE  
(State or country) Md.

10 NAME OF  
FATHER Thos Washington

11 BIRTHPLACE  
OF FATHER  
(State or country) Va.

12 MAIDEN NAME  
OF MOTHER Mary Robinson

13 BIRTHPLACE  
OF MOTHER  
(State or country) W. Va.

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Thos Washington  
(Address) Hagerstown

15 Filed 1-2-1915 Henry Davis  
REGISTRAR

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH Jan 1, 1915  
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from  
Jan 1, 1915, to Jan 1, 1915,  
that I ~~first~~ saw him ~~dead~~ alive on Jan 1, 1915

and that death occurred on the date stated above, at 9.30 p.m.  
The CAUSE OF DEATH\* was as follows:

Still born  
(Duration) — yrs. — mos. — ds.

Contributory Still born  
Secondary

(Duration) — yrs. — mos. — ds.

(Signed) Alley B Wilson, M. D.  
1/2, 1915 (Address) Hagerstown

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death yrs. mos. ds. In the State yrs. mos. ds

Where was disease contracted,  
If not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL Rose Hill Cemetery DATE OF BURIAL 1/2, 1915

20 UNDERTAKER Emmett Dow ADDRESS Hagerstown

# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

[Approved by U. S. Census and American Public Health Association.]

**Statement of occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Composer*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples:

(a) *Spinner*, (b) *Colton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At Home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the disease causing death, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer* (*retired 6 yrs.*) For persons who have no occupation whatever, write *None*.

## Statement of cause of death

Name, first, the disease

causing death (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Group"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia", unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritonaeum*, etc., *Carcin-*

*oma, Sarcoma*, etc., of..... (name origin); "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 d.; *Bronchopneumonia* (secondary), 10 d. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. For violent deaths state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *scaphis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.

RECEIVED  
FEB 6 1915

BUREAU, U. S. S.

## MARGIN RESERVED FOR BINDING

## WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH  
County Washington 1060  
V 189 STATE OF MARYLAND  
Village or City Hagerstown (No. 118, E. Franklin St. 4 Ward)  
[If death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME Ralph Wilcoxon

PERSONAL AND STATISTICAL PARTICULARS

3 SEX <u>male</u>	4 COLOR OR RACE <u>white</u>	5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word) <u>single</u>
6 DATE OF BIRTH <u>Sept 23</u>		(Month) (Day) (Year)
7 AGE <u>3 yrs. 24 mos. 24 ds.</u>		If LESS than 1 day, hrs. OR min. ?
8 OCCUPATION (a) Trade, profession, or particular kind of work. <u>None</u> (b) General nature of industry, business, or establishment in which employed (or employer) <u>"</u>		
9 BIRTHPLACE (State or country) <u>MD</u>		
10 NAME OF FATHER <u>Chas R. Wilcoxon</u>		
11 BIRTHPLACE OF FATHER (State or country) <u>Ohio</u>		
12 MAIDEN NAME OF MOTHER <u>Ruth Lightner</u>		
13 BIRTHPLACE OF MOTHER (State or country) <u>MD</u>		
14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE (Informant) <u>Ralph Wilcoxon</u> (Address) <u>118 E Franklin St.</u>		
15 Filed <u>1/27/28</u>	Henry Davis	REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH June 16  
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from Nov. 1 to Nov. 16, 1915, and that I last saw him alive on Nov. 16, 1915, and that death occurred on the date stated above at before 11 P.M. The CAUSE OF DEATH\* was as follows:

Unknown to me

(Duration) yrs. mos. ds.

Contributory  
Secondary  
(Duration) yrs. mos. ds.

(Signed) Merle G. Smith, M. D., 1915 (Address) 145 W. Main St., Hagerstown

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)  
At place of death yrs. mos. ds. In the State yrs. mos. ds.  
Where was disease contracted, if not at place of death?  
Former or usual residence.

19 PLACE OF BURIAL OR REMOVAL Rose Hill Cemetery DATE OF BURIAL 117, 1915  
20 UNDERTAKER G. M. Winters Son ADDRESS Hagerstown

# REVISED UNITED STATES STANDARD

## CERTIFICATE OF DEATH

[Approved by U. S. Census and American Public Health Association.]

**Statement of occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary foreman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework, or At Home*, and children, not gainfully employed, as *At school or At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the disease causing DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.)* For persons who have no occupation whatever, write *None*.

**Statement of cause of death**—Name, first, the disease causing DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Group"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritonaeum*, etc., *Carcin-*

*oma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Examples: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthma," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Con genital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. For violent deaths state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.

RECEIVED

FEB 6 1915

BUREAU, V. S.

## WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH County <u>Washington</u>		1061 STATE OF MARYLAND CERTIFICATE OF DEATH			
Village or City <u>Hagerstown</u> (No. 322) Jonathan		Registration Dist. No. <u>302</u>			
2 FULL NAME <u>James W. Wilkinson</u>		St. <u>5th</u> Ward			
[If death occurred in a hospital or institution, give its NAME instead of street and number.]					
PERSONAL AND STATISTICAL PARTICULARS					
3 SEX <u>Male</u>	4 COLOR OR RACE <u>Colored</u>	5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word) <u>Single</u>	MEDICAL CERTIFICATE OF DEATH		
6 DATE OF BIRTH <u>Sept 1, 1915</u>		16 DATE OF DEATH <u>1/29, 1915</u>	1	29	, 1915 (Month) (Day) (Year)
7 AGE <u>2 yrs. 4 mos. 28 ds.</u>		17 I HEREBY CERTIFY, That I attended deceased from <u>1/28, 1915</u> to <u>1/29, 1915</u>	that I last saw <u>him</u> alive on <u>1/29, 1915</u>		
8 OCCUPATION (a) Trade, profession, or particular kind of work. <u>Child</u>		and that death occurred on the date stated above, at <u>11 P.M.</u>			
8 OCCUPATION (b) General nature of industry, business, or establishment in which employed (or employer) <u>Child</u>		The CAUSE OF DEATH* was as follows:			
9 BIRTHPLACE (State or country) <u>Maryland</u>		<u>Obstruction of bowels - due to bands of adhesions</u>			
10 NAME OF FATHER <u>James Wilkinson</u>		(Duration) <u>1 yrs. 0 mos. 3 ds.</u>			
11 BIRTHPLACE OF FATHER (State or country) <u>W. Va.</u>		Contributory <u>Intrathoracic tuberculous</u> Secondary			
12 MAIDEN NAME OF MOTHER <u>Mozell L. Harris</u>		(Duration) <u>1 yrs. 0 mos. 0 ds.</u>			
13 BIRTHPLACE OF MOTHER (State or country) <u>W. Va.</u>		(Signed) <u>John Miller Jr.</u> , M. D. <u>1/30, 1915</u> (Address) <u>Hagerstown, Md.</u>			
14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE (Informant) <u>Mrs. Mozell Wilkinson</u> (Address) <u>Hagerstown, Md.</u>					
15 Filed <u>1/30-5 Henry Davis</u>					
16 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS) At place of death <u>0 yrs. 0 mos. 0 ds.</u> In the State <u>0 yrs. 0 mos. 0 ds.</u> Where was disease contracted, if not at place of death? Former or usual residence					
17 PLACE OF BURIAL OR REMOVAL <u>Hagerstown, Md.</u> DATE OF BURIAL <u>Jan 31, 1915</u>					
20 UNDERTAKER <u>A. P. Coffman</u> ADDRESS <u>Hagerstown, Md.</u>					

If more blanks are needed, address State Registrar, 6 E. Franklin St., Balto., Requesting V. S. No. 1.

# REVISED UNITED STATES STANDARD

## CERTIFICATE OF DEATH

[Approved by U. S. Census and American Public Health Association.]

**Statement of occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At Home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the disease causing death, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer* (*retired 6 yrs.*) For persons who have no occupation whatever, write *None*.

**Statement of cause of death**—Name, first, the disease causing death (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritonaeum, etc., Cancer*.

*oma*, *Sarcoma*, etc., of..... (name origin); "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Examples: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Anesthesia," "Anæmia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uraæmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "Puerperal septicæmia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent deaths state means of injury and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *scpsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.

